EFFECT OF MOTOR INSURANCE CLAIM MANAGEMENT AND CUSTOMER SATISFACTION IN THE NIGERIAN INSURANCE INDUSTRY

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A RESEARCH PROJECT SUBMITTED TO THE SCHOOL OF POSTGRADUATE STUDIES, NASARAWA STATE UNIVERSITY, KEFFI, IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE AWARD OF POSTGRADUATE DIPLOMA IN BUSINESS ADMINISTRATION (PGD)

DEPARTMENT OF BUSINESS ADMINISTRATION
FAULTY OF ADMINISTRATION
NASARAWA STATE UNIVERSITY, KEFFI
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DECEMBER, 2020.

DECLARATION

I hereby declare that this project has been written by me and it is a report of my research work. It has not been presented in any previous application for any Post Graduate Diploma in Business Administration. All quotations are indicated and sources of information specifically acknowledged by means of references.

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04-01-2020
Date

CERTIFICATION

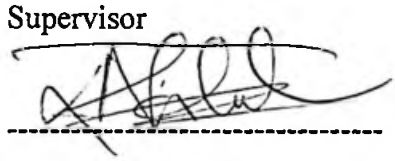
This project, "Effect of Motor Insurance Claim Management and Customer Satisfaction in Nigerian Insurance Industry" meets the regulations governing the award of Post Graduate Diploma (PGD) in Business Administration of the School of the School of Postgraduate Studies, Nasarawa State University, Keffi, and is approved for its contribution to knowledge.



04-01-2020

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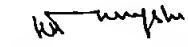
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DEDICATION

I dedicate this project work to God Almighty, creator of the universe.

ACKNOWLEDGEMENTS

It gladdens my heart to first acknowledge God Almighty who made it possible to complete this phase of my academic journey.

I am indeed privileged and grateful to have Dr. Vincent Paul as my project supervisor. I want to specially thank him for his support and assistance in writing this project work and also for taking his time assist me in developing my management techniques. May the good Lord continue to reach you at your point of need, Amen.

I also wish to express my unquantifiable appreciation the Dean Faculty of Administration, Prof. B. E. Barde, the HOD Business Administration, Dr. Abdul Adamu and all my lecturers, to mention few, Prof. S. B. Tende, Dr. (Mrs). R. A Andah and Dr. Ahmed Ibrahim for their contributions during my period of study.

A special feeling of gratitude to my lovely wife, Mrs. Uduakobong Prince Okokon whose words of encouragement and push for tenacity ring in my ears. Also to my Uncle, Hon. Victor, Mrs. Akpanamah and Utibe who never left my side at the course of my study and their various support in diverse way, I say a special thank you to you all.

I wish to thank my Boss, Mr. Ademoye Shobo, Mr. Adekunle Hamza, Mr. Mrs. Jonah Sunday for their immense supports towards this programme

Lastly to all those names were not mentioned, especially my colleague at place of work and my church members who have supported me throughout my programme. I appreciate you all for your supports and care, I pray that your heart desires would be granted.

ABSTRACT

The objective of this research was to examine the effect of motor insurance claims management process and customer satisfaction in the Nigerian Insurance Industry. The research identified five elements of the motor insurance claim management process in the Nigerian Insurance Industry, which are claim reporting, response to a claim, towing damaged vehicle damage assessment and repair handling. The motor insurance claim management included a sixth process complaint or dispute settlement for those raising any. Taking a sample of 102 customers selected using a convenience sampling technique from Nigerian Insurance Industry customers; the research examined the relationship between the elements of the claim management process and customer satisfaction. The results indicated that there is a statistically significant correlation between customer satisfaction and motor insurance claim management processes presented in their order of Pearson correlation coefficient (repair handling (0.783), damage assessment (0.745), complaint settlement (0.705), damaged vehicle towing (0.632), claim reporting (0.540), and response to a claim (0.205) with $p< 0.05$ or more). The regression model also confirmed that the model was significant with $F((6,95) = 38.914, p < 0.001)$, with an R^2 of 0.843. The model also identified repair handling with coefficient 0.341, damage assessment with coefficient 0.270 as strong predictors of customer satisfaction at $p<0.01$ followed by complaint and dispute settlement with coefficient 0.156 at $p< 0.05$. This implies that improving motor insurance claim management process could improve the overall customer satisfaction, which can also translate into policy renewals and further recommendation to others increasing the word of doorway advertising. Prioritizing and improving elements of the motor insurance claim management process specifically repair handling and damage assessment followed by complaint and dispute settlement' should result in higher level of customer satisfaction quickly.

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CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

Aiming to be efficient and effective in today's business environment and market place, industries have to evolve strategies, policies and practices that should be different from those used in the past; this is because of the continual changes in the business environment and the near unpredictable nature of the environment. However, this environment presents opportunities and threats which can be exploited or managed by prepared and forward looking organizations by crafting well-thought out strategies, policies and approaches (Kemelgor 2002; Osuagwu 2002). One of such strategies for a product like insurance will be the perceived quality of the product offered in the eyes of the customers.

The insurance industry in Nigeria consists of companies that are small by most standards to underwrite most policies and characterized by low penetration and patronage compared to its population. Nigeria has an estimated population of 140 million people according to 2006 census with an estimated non-life insurance income receipt of $787 million and life income receipt of $147million in 2009 (Staib & Louis, 2010). This leads to low insurance penetration of mere 0.6% (Staib & Louis, 2010) much lower than other emerging markets even in Africa with a majority of the policyholder been corporate bodies. This unsavory feature culminated to poor perception, low technology leverage, low investment and asset management capabilities and poor regulatory framework (Ahmad & Sungip, 2008).

Generally, the relevance of the insurance industry for the proper functioning of

economies and the players within it is beyond question. Not only it is functioning but also development, in the first place, depends on the soundness of financial systems of which the insurance sector is one of the major players. The business world without insurance is unsustainable since risky business may not have the capacity to retain all kinds of risks in this ever-changing and uncertain global economy (Ahmed et al., 2011). Insurance serves as a protection against economic loss arising due to an unexpected event (Butler & Francis, 2010). In other words, an insurance policy is designed to indemnify the insured against all sums for which the insurer is legally liable upon receipt of premium by the insurer in the occurrence of the peril insured against.

In an insurance contract, one party, the insured, pays a specified amount of money, called a premium, to another party, the insurer, who in turn, agrees to compensate the insured for specific future losses. The relevance of this relationship is clearly depicted in the statistics that show insurance customers in Nigeria have bought insurance worth reasonable amount.

For the insured, however, experience and financial strength of the insurer can only lead to satisfaction if only the promises made, specifically, payouts to claims, are made upon the occurrence of the covered incident. In the corporate world, this essence commonly termed as customer satisfaction is often seen as the key to a company's success and long- term competitiveness. Nyaguthii (2013), stated that customer satisfaction is one of the most important factors responsible for the sustained growth and profitability of an organization. This is no different for an insurance company. Barua (2015), indicates that customer satisfaction is the golden

key to the survival of an insurance company. Subashini and Velmurugan (2016), also emphasize that satisfied customers are backbone of any insurance company.

In recent years, insurance customers in Nigeria are increasingly aware of their expectations and standards of services required from their insurance companies. This is partly due to the fact that customers inclusive of motor insureds are more educated and knowledgeable about services provided by insurance companies. Therefore, it is becoming desirable and important for insurance companies to come up with approach that will give customer a central role for future growth and survival. In the same vein, insurance companies in Nigeria have also recognized the fact that service quality is imperative to achieve competitive advantage while poor quality brings about competitive disadvantage. Siddique and Sharma (2010), observed that quality insurance services help to differentiate one from others who are also offering identical services; also it offers a way of achieving success among competitors.

For insurance policyholder, the most important expectation from the insurer is claims settlement upon the event of the peril insured against. The right of the insured to receive the amount secured under the policy of insurance contract promised by the insurer is called claim (Butler and Francis, 2010). For Crawford (2007) cited on Yusuf et at (2017), claims are the most critical channels and defining a link that shape the overall perception of the customers towards their insurer and their satisfaction by the service it offers. Barua (2015), indicating the importance of claims for an insurance company, warns that any delay or negative behavior by the insurer during claim settlement creates customer dissonance. On the

positive 'claims handling offers a unique opportunity to develop a customer satisfaction and build a lasting relationship with them. Hewitt (2006) on Tajudeen and Adebowale (2013), therefore, rightly puts claims handling as the moment of truth for the insurance company an opportunity to fulfill the promise made to customers to pay a valid claim thereby resulting in a satisfied customer.

While claims management process offers an opportunity to create a positive experience for the customer, it also enables the insurer to control its claim management costs. Tajudeen and Adebowale (2013) defined claim management process as a combination of all managerial decisions and processes concerning the settlement and payment of claims in accordance with the terms of the insurance contract (Redja, 2008 cited on Tajudeen and Adebowale, 2013). Kelly (2008), points out that good claims management easily recognizes and allows paying legitimate claims; helps accurate assessment of the reserve associated with each claim; allows regular reporting; minimizes unnecessary costs; avoids protracted legal disputation and expedites claims handling. Wachira (2013), suggest maintaining a balance between assuring customer's satisfaction and maintaining cost efficiency.

Modernizing the claims process for efficiency, effectiveness and flexibility have been being a 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). However, Singh (2012), points at certain inefficiencies that are

driving up claims costs and adversely affecting customers' claims experience. These inefficiencies include aging technology, increasing process complexity, and arising number of fraudulent claims.

Studies in other parts of the world have indicated that efficient claims management led to customer satisfaction and poor claims management to the dissatisfaction of insurance customers. In the context of the Nigerian insurance industry, studies on the effect of claims management process on customer satisfaction are few to point out. Quite a number of recent studies such as Capgemini (2011a); Michael (2008) and Rose (2013), had revealed that insurance company's management of claims process is an integral link to its profitability and continuous survival, and also, mentioned that good claim management ought to be proactively conducted in acknowledging and paying claims legitimately; and then, evaluating accurately the claims reserve. According to the Association of Insurance and Risk Managers in Industry and Commerce (2009), paying claims legitimately is a representation of the delivery of the promise at the heart of the insurance contract, which in fact indicate excellent claims handling service that is considered as a differentiator that separate them from their competitors. An excellent claims handling service is an insurance company's competitive edge and thus, noted as a service that customer value greatly.

Capgemini (2011b) argued that a highly effective claims practice can be a vital contributor to attracting new customers and strengthening customer loyalty to produce a valuable customer experience. According to an earlier remark by the Organization for Economic Co-operation and Development (2004), a good

insurance claim management process should involve: claims reporting; receipt of claims by the company; claims files and procedures; fraud detection and prevention; claims assessment; timely claim process; complaints and dispute settlement; and supervision of claims-related services.

.2 Statement of the Problem

The success of any a service business is always attached to its ability to keep customers satisfied. Satisfaction is the customer's overall judgment of the service provider while with a positive judgment the customer can be maintained for a long time. Just like companies of other business domains, insurance companies also consider their customers as the most important asset.

The product a customer purchases from an insurer is peace of mind, based on the promise the insurer makes to him that he will be compensated in the event of the happening of the insured peril. For insurance customers, especially in the event of a peril, few things are as important as the claims payment and the claim handling process. Policyholders expect to have fair and hassle-free claim settlement process at the time of need (Butler & Francis, 2010). It can, therefore, be argued that a claim payment is a defining moment in the relationship between an insurance company and its customer (Tajudeen & Adebowale, 2013). In line with this, Butler and Francis (2010) put claim payment as a chance to show that the years spent paying premiums were worth the expense. According to Capgemini (2011b), the claims processing is the mirror to the customer that enables the insurers' drive.

For an insurer, claims payment is an opportunity to exhibition its commitment to its

customers contributing to customer satisfaction and long-term relationship. The claims management process offers a unique opportunity for insurers to deliver an experience that will allow a positive customer relationship to develop. EY (2010) and Yusuf (2017), also asserts that excellence in claims handling is being used as a competitive edge for insurance companies and it is a service that clients greatly value. For example, a survey of European motor insurance markets has shown that claims process is a key driver of satisfaction and pointed out that claims management should be a vital part of any successful customer retention strategy (EY, 2010).

On the contrary, dissatisfaction on claims is a crucial trigger for Switching (Accenture, 2014). The survey of European motor insurance markets has also shown that a small decline in satisfaction has a significant impact on customer behavior and that their claim experience has affected their tendency to thinking of switching insurer. According to Subashini and Velmurugan (2016), if policyholders are not satisfied in long run it will result in more number of terminations of the policies. Policyholders switch their insurer as a direct result of being unhappy with how their claim was handled hence the need for protecting the brand through efficient claims handling is a must (Accenture, 2014).

Even though the customer's expectation is to be paid without any delay, claim settlement process normally involves multiple systems, multiple processes, and multiple channels (Butler & Francis, 2010). A claim manager will have to ascertain whether the claim is payable, and if so, the amount payable. In order to do so, he relies on service providers including investigators, assessors, garages, hospitals,

doctors, advocates and loss adjusters. Yusuf (2017), also points out that for insurers; claims are their most significant expense. Insurers, therefore, need to keep a watchful eye on the customer experience (and perceptions) of claims handling to keep customers happy, while also trying to control costs and reduce leakage.

With all the problems identified however, Nigerian Insurance Industry have not yet conducted any research to assess how these problems are affecting their customers' satisfaction. Further, similar researches in the area also tend to focus on the general relationship between service quality and customer satisfaction. To the best of the researcher's knowledge, there is no research conducted in the area of the effect of claim management process and customer satisfaction.

With this in mind, assessing the effect of the claims management process on customer satisfaction should be an interesting and practical undertaking. This study therefore analyzed the effect of Nigerian Insurance Industry's motor insurance claims management process and customers' satisfaction with the aim of identifying practical implications.

1.3 Research Questions

In relation to the identified problem, this study tried to answer the following research question:

i. What is the motor insurance claim management process in the Nigerian Insurance Industry?

ii. How is the claim notification process affecting the customer satisfaction?

iii. How is the response to claim affecting the customer satisfaction?

iv. How is the damaged vehicle towing process affecting the customer satisfaction?

v. How is the damage assessment process affecting the customer satisfaction?

vi. How is the repair handling process affecting the customer satisfaction?

vii. How is the complaint and dispute settlement process affecting the customer satisfaction?

viii. What is the overall level of motor insurance customer's satisfaction in the Nigerian Insurance Industry?

1.4 Objectives of the study

The study general objective was to understand the effect of claims management process and customer satisfaction of motor insurance customers in the Nigerian Insurance Industry. While the specific objectives were to:

i. Understand the motor insurance claim management process in the Nigerian Insurance Industry.

ii. Assess the effect of the claim notification process on customer satisfaction.

iii. Examine the influence of response to claim process on customer satisfaction.

iv. Analyze the effect of towing a damaged vehicle process on customer satisfaction.

v. examine the effect of the damage assessment process on customer satisfaction.

vi. To determine the effect of the repair handling process on customer satisfaction.

vii. To determine the influence of complaint and dispute settlement process on customer satisfaction.

viii. To assess the level of motor insurance customer's overall satisfaction in the Nigerian Insurance Industry.

.5 Statement of Hypotheses

The following hypotheses were formulated as guides in line with the study objectives:

H_{01}: There is insignificant level of motor insurance claim management process in the Nigerian Insurance Industry.

H_{02}: Claim notification process does not significantly affect customer satisfaction.

H_{03}: Response to claim does not significantly affect customer satisfaction.

H_{04}: Damaged vehicle towing process does not significantly affect customer satisfaction.

H_{05}: Damage assessment process does not significantly affect customer satisfaction.

H_{06}: Repair handling process does not significantly affect customer satisfaction?

H_{07}: Complaint and dispute settlement process does not significantly affect customer satisfaction.

H_{08}: There is insignificant overall level of motor insurance customer's satisfaction in the Nigerian Insurance Industry.

1.6 Significance of the Study

The study is important in various ways to stakeholders in the insurance industry. Practitioners in the Nigerian Insurance Industry, the industry will primarily be able to understand the impact of their motor insurance claims management process and satisfaction of their customers. Besides pointing out which processes are primarily influencing customers' satisfaction; the research could also shade light some necessary revisions in the claim management process. Based on the outcomes, designing workable claim management processes that will help to create and deliver customer value, achieve customer satisfaction and loyalty, build beneficial relationships with customers that will achieve sustainable business growth for Nigerian Insurance Industry.

Other practitioners in the industry could also use the outcome of this research as a benchmark to evaluate their claims management process. Further, other researchers can use it as an input for doing similar research in the insurance industry.

1.7 Scope of the Study

Due to the limited time and financial resources, the scope of this study was geographically limited to Nigerian Insurance Industry', customers in the Federal Capital Territory, Abuja-Nigeria. Conceptually, the effect of motor claims management process on customer satisfaction was only looked at from the perspective of motor insurance customers. Hence the scope was only limited to customers side and did look at it from the company's perspective. Additionally, only a quantitative survey was used as a data collection method and other methods like

an interview or group discussion was not conducted. Data were also collected at one point in time hence a cross- sectional study.

1.8 Definition of Operational Terms

Insurance: Insurance is a mechanism by which an organization can exchange its uncertainty for greater certainty. It is an economic device whereby the individual or business pays a cost (premium) in exchange for protection against financial loss.

Insurance Policy: is a formal contract-document issued by an insurance company to an insured. The policy puts an indemnity cover into effect, serves as a legal evidence of the insurance agreement sets out the exact terms on which the indemnity cover has been provided, and states associated information. The information includes specific risks and perils covered, duration of the coverage, amount of premium, mode of premium payment, and deductibles, if any.

Premium: The payment, or one of the periodical payments, a policyholder agrees to make for an insurance policy. It is the amount paid to an insurance company, sometimes in regular installments or as per the agreement with the insurer for the insurance policy.

Claim: Demand made by the insured, or the insured's beneficiary, for payment of the benefits as provided by policy. Claim is a formal request that's made either by a plan participant or his or her healthcare provider to the insurance company, asking for payment for a procedure the member received.

Claim Management: claim management also referred to as claims handling covers all the necessary steps starting from the notification of incident by the customer all

the way to settlement. The claim management process, while requiring to pay all claims as per the policy terms fairly and promptly, guarding against fraud, minimizing costs and assuring customers satisfaction.

Motor Insurance: motor insurance covers the insured in respect of loss or damage to the insured vehicle or other impacted by the insured vehicle.

Customer Satisfaction is a measure of how products and services supplied by a company meet or surpass customer expectation.

CHAPTER TWO

LITERATURE REVIEW

2.1 Conceptual Framework

2.1.1 Concept of Insurance Claim Management

A claim on an insurance policy, according to Krishman (2010), is a demand on an insurance company to fulfill its portion of the promise, committed to while writing the contract with the insured. Asokere and Nwankwo (2010), defined a claim as a demand made by the insured person to the insurer for the payment of benefits under a policy. Brooks, Popow and Hoopes (2005), earlier submitted that an insurance claim is also a demand by a person or an organization seeking to recover from an insurer for a loss that an insurance policy might cover. A claim, according to Vaughan and Vaughan (2008), is described as a notification to an amount is due under the terms of a policy.

However, Francis and Butler (2010), described claim as a defining moment in the relationship between an insurance company and its customer. Similarly, such relationship can become healthy if the insurers are able to address five key issues such as: taking greater control of the claim process; understanding their customer; choosing the right claims model for their business; developing a mutually beneficial relationship with other service providers; and gaining an information advantage. Singh (2012), opines that insurers can transform the claims processing by leveraging modern claims system that are aligned with robust business intelligence, document and content management system that will improve claims processing efficiency and effectiveness.

Jacob (2007), noted that the core challenges driving business costs in claims processing involve: responsiveness; flexibility and management of workflow; supply chain management; and business intelligence. Association of Insurance and Risk Managers in Industry and Commerce (2009), argued that the key components that must be in place in a bid to delivering excellence in insurance claims handling include: culture and philosophy, communication, people, claims management, infrastructure, date management, operations, and monitoring and review. According to Esri (2012), the five steps for optimizing the insurance claims process involve: data organization; analysis and planning; mobility; management and customer engagement.

Goel (2013), was of the opinion that claims processing involves some tasks such as: following up with the claimant or third party for missing documentation and validating that all required claim information has been collected. It was arguably considered thus that claim managers ought to focus only on the most significant claim tasks that required their attention, and also optimizing the use of their time. According to Singh (2012), for insurers to attain operational efficiency and effectiveness in claim process, they must look directly at implementing modern claims system; leveraging advanced fraud detection technologies and creating innovation around their self-service claim processing activities. IBM (2007), expressed that those involved in the management of claims seek to achieve: increased efficiency in their claims handling process; improved control over the process with a view to managing and guaranteeing service levels; seamless integration across the end-to-end claims process; greater flexibility within the

process to respond to changes within the market; and the ability to deliver this across multiple distribution channels to their customers and partners.

Benefits that have been alluded to effective claims management process, according to Capgemini (2011c), were noted as: improved customer service; reduced indemnity costs, improved claims handling and administration; reduction in allocated loss adjustment expresses; improved operational management; improved enterprise risk management; enhanced business agility; and core brand differentiation. According to an earlier submission by the Productive Commission (2002), a good claim management process is expected to include: proactiveness in recognising and paying legitimate claims; assessing exactly the reserve associated with each claim; reporting regularly; minimising unnecessary costs; avoiding protracted legit disputation; dealing with claimants carefully; and expediting claims handling.

Amorose (2011), opined that the key areas insurers should take critical look at in achieving operational excellence in claims management are: leveraging advanced analytics, supplier management, legal cost management, technology enablement, and fraud detection. According to Wilberforce (2015), claims process commences at underwriting function which is guided by structured losses experience data. An experiential revelation by Jacob (2007), noted that in addressing the various challenges in the insurance claims management process, a set of technology-related processing significant to enhancing claim have been identified as follows: (i) An integrated and flexible architecture; (ii) Business intelligence enable by more sophisticated data management, analysis and reporting throughout the enterprise;

(iii) Deeper integration of business processes, as well as visibility provided by monitoring, alerts, and reporting; (iv) increased collaboration; (v) support for mobile workers; (vi) cost-effective migration from legacy systems; and (vii) industry and technology standards.

.1.2 Concept of Customer Satisfaction

Customer satisfaction plays an important role in business strategy and acts as a key factor in the sustainable development of companies (Gronroos, 1984; Lovelock & Wirtz, 2007). Many studies define the concept of satisfaction. According to Kotler (2000), the level of customer satisfaction is assessed by comparing a perception of a product/service in relation to the expectation of customers. Many studies have proven the relationship between service quality and customer satisfaction (Terblanche & Boshoff, 2006). In addition, according to (Sarstedt, Wilczynski & Melewar, 2013), these studies have agreed that corporate image has a positive effect on perceived value and customer satisfaction. In addition, Young Dan and Kathy (2013), suggested that perceived value positively influences customer satisfaction.

Not like in other commercial contracts, insurance contracts are mainly based on the principle of utmost good faith and the attraction of potential customers and retention of the existing customers mainly depend on customer satisfaction. Consumer satisfaction has been conceptualized in the marketing literature as the difference between perceived performance of a product/service and some cognitive standards such as expectation and desire of consumers (Oliver, 1980; Cronin &

Taylor, 1992). In this regard satisfaction is the result of perceived product performance and some expectation or desire of consumers. This results in a confirmation or disconfirmation of customer expectation and desire.

Satisfaction is a person's feeling of pleasure or disappointment resulting from comparing a product's performance (outcome) in relation to his or her expectation (Kotler & Keller, 2006). Accordingly, satisfaction is a psychological effect that involves the feeling of wellbeing and pleasures that result from obtaining what one hopes for and expects from the product and/or service. Oliver (1993), suggest that. Customer satisfaction is a consumer's post-purchase evaluation and affective response to the overall product or service experience. Customer satisfaction is driven by perceived price or value. Though the concept of value is relative and has several dimensions to it, Zeithaml (1988), considers customers value as the overall assessment of the utility of a product based on perception of what is received and what is given.

Customer satisfaction is one of the main areas of interest in marketing, business and the academic world (Tikkanen & Alajoutsijaui, 2002). According to Peter and Olson (1996), and Howard and Sheth (1969), customer satisfaction is "the degree to which a consumer's repurchase expectations are fulfilled or surpassed by a product or service." Customer satisfaction is known to be one of the most important and serious issues towards success in today's competitive business environment, as it affects company market shares and customer retention (Ooi, Abdul-Rahman, Lin & Yee-Loong, 2011).

Kauppinen-Raisanen (2007), view that the implication of the antecedents of

customer satisfaction is that managers must take effective strategies to manage customer perceived quality, customer expectations, and customer perceived value in order to reap the full benefits of customer satisfaction measurement. Bruhn (2003), views customer satisfaction as an experience based assessment made by the customer of how far his own expectations about the individual characteristics and other overall functionality of the services obtained from the provider have been fulfilled. More recent studies view satisfaction as an outcome or end result during the process of the consumption of a service; it is viewed as a post-purchase experience (Vavra, 1997).

.1.3 Concept of Insurance

The term insurance describes any measure taken for protection against risks and its definition are as many as the insurance professionals themselves. Akintayo (2004), for example, defines insurance as a policy designed to indemnify the insured against all sums for which the insurer is legally liable upon receipt of premium by the insurer in the occurrence of the peril insured against. Epetimehin (2010), views insurance as a financial mechanism which aims at reducing the uncertainty of loss by pooling a large number of uncertainties so that the burden of loss is distributed. Sowden (1989), argues that Life Assurance is a contract whereby a customer agrees to make regular payments (premiums) for a fixed period and the insurance company invest it in shares, land or property and at the end guarantees to pay a lump sum depending on the exact nature of the insurance contract. Irrespective of how the authors put it, one thread is common to all the definitions; insurance is a modern

concept for solving risk- related problems depending on the cooperation of a large number of people for its success.

In an insurance contract, one party, the insured, pays a specified amount of money, called a premium, to another party, the insurer. The insurer, in turn, agrees to compensate the insured for specific future losses. The losses covered are listed in the contract and the contract is called a policy. When an insured suffers a loss or damage that is insured in the policy, the insured can collect on the proceeds of the policy by filing a claim with the insurance company. The company then decides whether or not to pay the claim. The recipient of any proceeds from the policy is called the beneficiary who may be the insured person or other persons designated by the insured (Nebo & Okolo, 2016).

Three main parties are involved in the provision of insurance services: the insurance company (usually called the insurer). The customer (usually called the insured) and the third party are usually the brokers, commission agents, the government, individual, organizations and the general public who may be using the insurance services or are involved in insurance in one way or the other (Nebo & Okolo, 2016).

The insurance company, is the main service provider of all insurance related needs of her customers and provides a full range of service to its customers e.g., issuance of insurance certificates, issuance of policy document, and physical survey of property insured, claim processing, loss adjusting and settlement of claims. It also offers different types of policies to different categories of customers. Insurance business can be classified into two categories according to Nwite (2004), namely, General Business otherwise known Non-Life insurance business and Life

Assurance business for customers who insure their lives for the benefit of another. In support of the above classification of insurance, Akintayo (2004), agrees with Nwite (2004), went further to painstakingly identify various types of General Insurance Business namely: Property Insurance, Pecuniary Insurance, Accident Insurance, Liability Insurance, Motor Vehicle Insurance, Engineering Insurance, Marine Insurance, Aviation Insurance; then Life Assurance.

The Insured is the individual, organization or person who insures his property or asset with the insurance company and pays the premium to the insurance company. In most cases, he is also the one to be compensated in the case of claim occurrence and indemnity settlement whether full, partial or ex-gratia payment. The insured could be the general public, state government, federal government, social club, church, individuals, companies, local government, industry, professional association, commercial companies, and private hospitals among others.

The third parties to the insurance company could be the insurance brokers, insurance agents, individuals and the general public who are connected one way or the other with the subject insured. For instance, Nwite (2004), describes the insurance agents as covering part-time agents, full-time agents, cash agents, credit agents, own case agents etc., whilst the brokers are limited liability companies registered under the Insurance Decree or Act of 2003 to transact insurance broking business and they are independent operators who may be held liable for professional negligence due to their expert knowledge whilst agents are not. It is important to mention here that brokers usually earn brokerage commission for their services to the insurance companies whilst the agents earn commission. The main

function of the brokers and agents is to bring the insurer and the insured into a contractual relationship of insurance.

The main purpose of insurance marketing is to meet the needs of the insurance customers and in turn achieves the organizational goal. This is gotten through some key techniques that an insurer utilizes for customers' satisfaction. Some of these techniques are prompt claim settlement, efficient service delivery, interaction with customers to solve their problems, distribution of corporate gifts, home delivery of claims and commission cheques to customers, brokers and agents, quality service as well as prompt attendance to customers' complaints, prompt renewal notices sent to customers to avoid embarrassment by government officials in case of motor insurance, issuance of cover notes as temporary insurance before premium payment, among others (Nebo & Okolo, 2016).

Insurance is a social device, in which a group of individuals called "Insured" transfer risk to another party called the "Insurer" in order to combine loss experiences, which permits statically prediction to losses and provides for payment of losses from premiums by all members who transferred risk (Zeleke, 2007).

A method where by the uncertain risks of industries are combined in a group through payment of individual contributions out of which losses are reimbursed to those who sustain them is referred to as insurance. It involves two parties namely the insured the one who transfers his/her risk buying the insurance and the insurer the one who bears the risk (Reja, 2002).

An insurance company insurer is able to offer protection by grouping individuals who all feel exposed to the same type of risks. The individuals are grouped based

on the homogeneity of the risks they feel they are exposed to so as to pay the compensation in a relative ease when the unfortunate one of them suffers a loss (Reja, 2002).

Each insured individuals pay a relatively smaller fee, which is termed as 'premium' to the insurer company. The fee is very small compared to the loss transferred to the insurer (relative to the sum insured). When a risk happens; the insurer compensates the unfortunate individual from the pool of this collected fund (Reja, 2002).

People seek security. A sense of security may be the next basic goal after food, clothing, and shelter. An individual with economic security is fairly certain that he can satisfy his needs (food, shelter, medical care, and so on) in the present and in the future. Economic risk (which we will refer to simply as risk) is the possibility of losing economic security. Historically, economic risk was managed through informal agreements within a defined community. If someone's barn burned down and a herd of milking cows was destroyed, the community would pitch in to rebuild the barn and to provide the farmer with enough cows to replenish the milking stock. This cooperative (pooling) concept became formalized in the insurance industry. Under a formal insurance arrangement, each insurance policy purchaser (policyholder) still implicitly pools his risk with all other policyholders (Andersson, 2005).

Zeleke (2007), also defines insurance as a social device, in which a group of individuals called; Insured transfer risk to another party called the –Insurer‖ in order to combine loss experiences, which permits statically prediction to losses and provides for payment of losses from premiums by all members who transferred risk.

Motor Insurance

Motor vehicles made their first spluttering appearance at the turn of the 20th century. At that time, they were much slower and so cumbersome than the common horse and carriage. As a result, during the early years of motoring, there seemed little need to consider the implications and requirements of insurance. By the time of the First World War, a motor vehicle was developed and improved with the change in technology and to comply with considerable interest for the motor car (Talk Once, 2010). In the process of building an affluent society, a car has changed from luxury consumer goods to an ordinary merchandise which as a result is causing frequent traffic accidents. Accidents arise from poor standards of driving skills, little road discipline as well as technical challenges (Bao & Gu, 2014).

Motor insurance is generally measured non-life insurers' strongest class of business in terms of premium volume and promotion tool. Currently, motor insurance in Nigeria covers the following perils:

a. By accidental collision or overturning consequent upon mechanical breakdown but excluding damage to tires unless such insured motor vehicle is damaged at the same time, and wear and tear.
b. By fire, external explosion, self-ignition, lightning, theft or attempted theft.
c. By malicious act.
d. Whilst in transit (including the processes of loading and unloading incidental to such transit) by road, rail, inland waterway, lift or elevator; and
e. By impact damage caused by falling objects provided no convulsion of nature such as flood, typhoon, hurricane, volcanic eruption, earthquake etcis

involved.

Customers of motor insurance like any other services expect to get the service they paid for. One of the key elements of the service is getting payouts in the event of an incident/damage to the vehicle insured. The satisfaction of customers partly depends on the quality of the service during the claim. Below, concepts like service quality and customer satisfaction in general and in the case of insurance companies are discussed.

Benefits of Insurance

Insurance, like most institution presents society with various benefits. Peace of mind, indemnification, keeps families and business together, provides a basis for credit, stimulate savings and provides investment capital are the most important general benefits of insurance (Dickson, 1999 cited in Yosef, 2018).

Peace of Mind: Almost everyone has a basic desire for some security or peace of mind. To the extent that insurance provides certainty or predictability, it helps an individual or business improving efficiency of actions by reducing anxieties.

Indemnification: The direct advantage of insurance is indemnification for unexpected loss, which means, putting one to the same position he/she was before the unfortunate events occurred.

Keep Families and Business Together: The existence of insurance often supplies financial aid at time of death of family or damage of property due to unforeseen events.

Provides a Basis for Credit: One finds it impossible to visualize the credit

economy of today without insurance. For instance, fire insurance is invariably used by mortgages who loan money with real or personal property as collateral. Banks would not dare to grant any loans without making sure there is some institution or someone that will pay them their money if the unfortunate happens to the collateral they hold against the credit granted.

Stimulates Savings: classes like life insurance have special advantages in stimulating savings.

Provides Investment Capital: Insurance premiums normally are paid in advance of losses and held by insurers until the time of claim payment, which allows insurers to invest it.

2.1.4 Importance of Claims Management in the Insurance Sector

According to Keefer (2010), proper claim management provides the following benefit, in addition to the competitive environment in which insurance companies operate, these businesses are challenged by more stringent compliance with government regulations and increasing expectations on the part of consumers. Efficient claims management is vital to the success of both large and small companies working within the insurance industry. Major components of the claims handling process include developing strategies to cut costs and reduce fraud while keeping customers satisfied. Small companies in particular can benefit from claims management tools and technology.

Settling Claims

Settling insurance claims is just one aspect of the claims management process. The time it takes to process a claim involves several stages beginning with a person filing a claim. The stages that follow determine if a claim has merit as well as how much the insurance company will pay. Insurance customers expect a company to settle claims quickly and to their satisfaction. Because high customer satisfaction levels can give a company a competitive edge, reducing the time it takes to settle insurance claims is one way to decrease the number of customer complaints and improve service. The use of claims management system software that speeds the process and minimizes costs offers a practical solution. Simplifying the claims process through automation helps reduce expenses for smaller companies that operate with smaller budgets (keefer, 2010:167).

The basic purpose of insurance is to provide for the group who suffer losses. This is accomplished in the claim settlement process, but it is sometimes a great deal more complicated than just passing out. The payment of losses that have occurred is function of the claim department (Assefa, 2004).

Detecting Fraud

Paying fraudulent claims costs insurance companies money a cost the insurance industry then passes on to its customers. Consequently, underwriting guidelines become tougher and the insurance premiums consumers pay increase. Software tools designed to examine payment history and evaluate trends in claim payoffs can help insurance companies detect fraud, according to Wipro, a global IT business.

For example, how often the same individual files an insurance claim can be a warning that a person might be filing a fraudulent claim. Unfortunately, settling claims too quickly increases a company's chance of paying out on a greater number of fraudulent claims. Unlike large companies that can absorb some losses as a part of doing business, small companies quickly suffer the negative effect on net earnings when paying fraudulent claims. Then again, processing insurance claims too slowly increases the risk of losing dissatisfied customers. In a highly competitive insurance market, small companies can't afford to lose customers (Keefer, 2010).

Lowering Costs

Monitoring costs throughout the claims management process determines how much of a customer's premium rate goes toward paying for the insurance company's administrative costs. Generally speaking, when settling a claim is delayed, it costs the insurance company more money. The higher claim costs reduce profitability. For small and large insurance companies alike, automation of some of the claims management process can help decrease a company's operating costs. One example is the increased cost of investigating a claim manually. Information technology systems, though, improve efficiency by decreasing the number of claim errors, detecting fraud early and reducing the time it takes to process and settle a claim all factors that cut an insurance company's costs and increase profitability. Even in a healthy economy, running a small business can be tough. Other essential functions of the claims management process that can reduce costs include developing

programs directed at preventing claims before they occur and avoiding future claims (Keefer, 2010).

Avoiding Litigation

In most cases involving insurance claim disputes, the insurance company eventually agrees to pay an equitable amount if a customer has a legitimate claim and can present evidence supporting it. Although quickly settling a claim can avoid the chances for litigation, accurate liability assessment is crucial to achieving a quick resolution in a claim dispute. Insurers work to evade litigation because it substantially increases the company's cost of settling a claim. For instance, one-time cases where a person misrepresents information he provides on an insurance application can be expensive for an insurance company to prove legally. Causing a company financial loss is another reason to avoid litigation. Small insurance companies are not immune but rather are increasingly exposed to potential litigation involving claim disputes (Keefer, 2010).

Profitability

Customer satisfaction has a positive effect on organisation's profitability. It leads to repeat purchase and positive word-of-mouth advertising. Satisfied customers are most likely to share their experiences with other people and dissatisfied customers tell more people their unfortunate experiences. Aaker (1995), asserts that strategic dimension for an organization includes becoming more competitive through customer satisfaction, brand loyalty and product/service quality. Customer

satisfaction is not an end in itself but a means to achieving greater profit in firms. For instance, Kotler and Keller (2009), advocate that satisfied customers tend to be less price sensitive, more willing to buy additional products and less influenced by competitors. Satisfied customers generally stay loyal and longer, buy more as firms introduce new products, upgrade existing products, talks favourably to others about the company and its products, offers product ideas to the company and cost less than new customers because transactions can become a routine.

Customer Loyalty and Retention

The strategic imperatives for building a loyal customer are: focus on key customers, anticipate the needs of customers and respond to them before competitors do, build close ties with customers and create a value perception. As long as customers feel they are receiving better value than they would obtain from another firm, they would increase their loyalty and retention. Customer satisfaction is very important in today's insurance business world because it makes the customers loyal and helps the organization to build long and profitable relationships with their customers

1.5 Relationship between Service Quality and Customer Satisfaction

Quality and customer satisfaction have long been recognized as playing a crucial role for success and survival in today's competitive market. Considerable research has been conducted on these two concepts.

Whereas there exists a widespread agreement that understanding what contributes to customer satisfaction could be the key to achieving competitive advantage, an

overview of the literature shows that as a theoretical construct, customer satisfaction is problematic to define and operationalize, especially in relation to perceived service quality. Some authors have suggested both that perceived service quality and customer satisfaction are distinct constructs, and that there is a causal relationship between the two (Taylor & Baker, 1994). In some cases, however, the constructs have been used interchangeably. It would seem that at the most general level, perceived service quality and customer satisfaction are evaluation or appraisal variables related to customer judgments about a product.

Satisfaction is defined as the consumer's fulfillment response, the degree to which the level of fulfillment is pleasant or unpleasant. Therefore, satisfaction is the customer's overall judgment of the service provider (McDougall and Levesque, 2000). Crompton and MacKay (2002), state that satisfaction is a psychological outcome emerging from an experience. Customer satisfaction can also be a measure of how products and services supplied by a company meet or surpass customer expectation (Farris et al, 2010). Measuring customer satisfaction provides feedback on how successful an organization is at providing products and/or services to the satisfaction of customers.

On the other hand, service quality is defined as the customer's impression of the relative inferiority/superiority of a service provider and its services and is often considered similar to the customer's overall attitude towards the company. Service quality takes a prominent position in the marketing management literature. Researchers have tried to conceptualize and measure service quality and explain its relation to the overall performance of companies and organizations (Bitner &

Hubert, 1994).

A common denominator of research on service quality is the conclusion that, because services are intangible, heterogeneous, and their production and consumption are usually inseparable, the process used by customers to evaluate service quality is exceptionally composite and cannot be easily identified. The idea that services are evaluated both by the outcome and by the production and delivery, process is commonly accepted.

By defining perceived quality as the customer's long-term, cognitive evaluations of a company's service delivery, and customer satisfaction as a short-term emotional reaction to a specific service performance, Lovelock and Wright 30 bring the time dimension into discussion. They argue that satisfaction is by default experience-dependent as customers evaluate their levels of satisfaction or dissatisfaction after each service encounter. In turn, this information is used to update customer perceptions of quality. However, quality attitudes are not necessarily experience-dependent (for example they can be based on word of mouth or advertising). In other words, it is satisfaction that determines quality and not vice versa.

Oliver (1997), research on the direction of the causal relationship between perceived quality and satisfaction adds to the discussion by indicating that the direction depends on the level at which the measurement is conducted: at the single-transaction level there is a strong quality – affects – satisfaction relationship; and at the multiple-transaction level there is a strong satisfaction affects quality relationship, as overall satisfaction judgments influence consumers' views about perceived quality. Parasuraman et al (1994), address these issues directly by

developing two different models: a single-transaction (encounter) model and a multiple-transaction (global) model, in which they differentiate between past and present transactions. However, in both models it is perceived quality that influences customer satisfaction. Thus, their work supports the dominant view in the literature: that with regard to quality satisfaction is the super-ordinate construct.

1.6 Service Quality and Customer Satisfaction in the Insurance Industry

Like any other service business, the quality of service and the resulting satisfaction of customers is a paramount concern for insurance services. Insurance providers increasingly recognize that today's customers who insist on improvements in quality of services have many alternatives and, therefore, may more readily change providers if not satisfied. This is evident from the practice of policy termination taken by dissatisfied policyholders which is not uncommon. Research has shown that the quality of services and the achievement of customer satisfaction and loyalty are fundamental for the survival of insurers (Yusuf & Ajemunigbohun, 2015). The decrease in customer loyalty has made management of service quality and customer satisfaction critically important factors for insurance players. Taylor (2001), concluded that the quality of after sales services can lead to very positive results through customer loyalty, repetitive sales and cross-selling. Insurance providers need to reconfigure their strategy and business to sustain or improve their competitive advantage, and for this, they first need to consider how to create a satisfied customer base that will not be eroded even in the face of fierce competition (Siddiqui & Sharma, 2010).

A significant portion of the service an insurance customer receives is settlement of claims in accordance with the terms of the insurance contract. From an insurance company viewpoint, claim management is a key element in the competition between insurance providers and for the improvement of its public image (OECD, 2004). While claims management process offers an opportunity to create a positive experience for the customer, it also enables the insurer to control its claim management costs. On the other hand, claim management service quality and effectiveness, is said to be the basis on which an insurance company is ultimately judge by clients and the key issue affecting the reputation of the insurer (Yusuf & Ajemunigbohunb, 2015). The payment of legitimate claims to a client represents the delivery of the promise at the heart of the insurance contract.

Customer satisfaction in insurance means the use of policy product purchased for a cost, to ultimate satisfaction of the buyer. A survey conducted on European motor claims has shown that insurers have managed to create customer satisfaction by placing customers at the heart of their claims process (EY, 2010). Kiana (2010), in his identification of challenges in claims, he indicated elements of the claim management process like assessment, reporting a claim and participants like agents and brokers are causes of customer dissatisfaction. Wachira (2013), also indicated that efficient claims management process is one of the key success factors for the Kenyan insurance industry.

.1.7 Claims Management and Common Procedures

Claims management is critical to an insurer's success. Done right, it solidifies customer relationships. Tajudeen and Adebowale (2013), defined claim management process as a combination of all managerial decisions and processes concerning the settlement and payment of claims in accordance with the terms of the insurance contract (Redja, 2008 cited in Tajudeen & Adebowale, 2013). Wedge and Handley (2003), define Claims Management as the carrying out of the entire claims process with a particular emphasis upon the monitoring and lowering of claims costs. The two definitions combined together suggest that the claims management process has to strike a balance between customer expectations and maintaining cost efficiency.

A customer's expectation, during a claim, is to be paid without any delay, while a claim manager will have to ascertain whether the claim is payable, and if so, the amount payable. This process requires inputs from various service providers including investigators, assessors, garages, hospitals, doctors, advocates and loss adjusters. The service provider may not attach the same priority to a customer as the insurer, resulting to slow turnaround time and complaints from customers.

Although different insurers follow different procedures, some of the basic elements include claims notification, claim review, responding to claimants, claim investigation, claim settlement and claim recovery if required. Understanding the importance of claims management, OECD Insurance Committee had documented and published best practices in claim management practices. Activities the OECD guideline identified as important include: adequate information and assistance to the

policyholder for claim reporting; efficient claim filing methods; operational fraud detection and prevention measures; adequate, fair and transparent claim assessment and processing; expeditious claim settlement; effective complaint and dispute settlement procedures; and appropriate supervision of claims-related services (OECD, 2004). The various stages a claim goes through from its occurrence to conclusion are:

Claim Notification: most policies state that the insured should notify their insurer of a claim promptly. The initial report may be verbal, though the insured will be required to give further information by completion of a claim form. For liability claims, the insured is required to forward to the insurer all correspondence from the claimants or their advocates. It is the insured's responsibility to prove that they have suffered a loss, and the loss was caused by a peril, which is covered by the policy. The client must also prove the amount of loss, such proof being by way of purchase receipts, repair account or a valuation (Roff, 2004).

When a claim is not reported promptly, the insurer misses out the opportunity to investigate facts when they are still fresh. Other factors also come into play, which may aggravate the loss. Besides, an insurer needs to separate genuine claims from fraudulent ones. Late reporting makes this separation difficult.

The OECD guideline recommends that the insurance company should draw the attention of the policyholder to report claims timely during the signing of the policy. The guideline also recommends that the insurer prepares appropriate claim reporting forms and provide necessary information to help the client report the claim (OECD, 2004).

Claim Review: involves analysis of the claim and includes comparison of information in claim form with what was provided in the proposal form, interpretation of the policy in light of the claim, economic considerations such as decision on whether the claim is too small to warrant further investigations or the need to call for additional documentation. Alternatively, a large claim may justify further investigations or legal action. The insurer needs to check that the policy was in force at the time of loss, the insured's details are as per proposal form, the peril insured against is covered by the policy, the insured has complied with the policy terms and conditions and that the loss claimed against does not fall under an exclusion.

Claims review is a crucial stage in the claims process; where likely conflicts arising from policy interpretation, economic considerations, market practice and legal requirements. A senior claims handler needs to be involved at this stage, in order to handle major issues accurately and promptly, including properly investigating the claim if need be (James, Lyn & Rowe, 2009).

The OECD guideline suggests that the insurer establishes a compliance programs for combating fraud, discourage fraudulent practices by making the policyholder/claimant/beneficiary aware of the consequences of submitting a false statement (which in particular could be liable to prosecution) and/or an incomplete statement (OECD, 2004).

Response to Claimant: the initial response is usually an acknowledgment, or a request for further information. Once the insurer is satisfied with information given, they either convey decision to pay, or decline to pay the claim. A third response may

be offered to pay a lower amount than that claimed or enter into negotiations with the insured, without initially making any offer on amount. This is in a situation where liability is accepted, but insurer is not satisfied with amount claimed. Whether the insurer intends to decline a claim, or enter into negotiation, they must convey to the insured their reasons for the decision, to ensure the insured is satisfied with the decision and avoid the insured resorting to litigation (James, Lyn & Rowe, 2009).

Claim Investigation: in some cases, the insurer may not have full facts of the claim and is unable to make a decision on a claim. They may therefore require appointing an investigator, to carry out investigations and file a report to the insurer. This is mainly for motor and liability claims. Investigations are also necessary if a claim is suspected to be fraudulent. The nature of other claims requires an insurer to appoint a loss adjuster, to establish liability and quantum of the claim. This is especially for property claims, including Fire, Burglary, Domestic Package, All Risks, and Marine among others.

In the case of motor claims, a motor assessor assesses the extent of damage to the vehicle and establishes the cost of repairs. The assessor also advises whether to repair the vehicle or treat it as a constructive total loss and pay insured pre-accident value of the vehicle. Once investigations are completed, the insurer is expected to convey findings and next course of action to the insured. The investigator must exercise speed but also be efficient. The report should be comprehensive, covering all the salient features of the claim, while bringing out the issues in an orderly and clear manner (Wedge & Handley, 2003).

Besides the above points, OECD (2004) recommends the establishment of internal methods for assessing claim by the insurance company, clarifying the role of claim adjusters, as well as ascertains their competence and qualifications.

Claim Settlement: where liability is not in dispute and both insurer and insured are in agreement on quantum, settlement follows immediately. However, in situations where either liability or quantum is in dispute, the claim is delayed. OECD (2004), points out that after an agreement has been reached between the insurer and the policyholder (claimant or beneficiary) on the amount of compensation, the payment should be completed within a reasonable amount of time. A quick claims settlement as well as high quality and punctual information provided to the policyholder (claimant or beneficiary) are key competition features for insurance companies. In case of any delay, the guideline recommends that the insurance company as soon as possible should advise in writing the policyholder (claimant or beneficiary) on the reasons for any delay and resolution (OECD, 2004).

Complaints and Dispute Settlement: in cases where the client has complaints or goes in to disputes, OECD (2004), suggests that complaints or disputes be filed, acknowledgement of the receipt of the complaint to the client within a reasonable period of time be made, explain how their complaints will be handled and on the procedures of follow up. Complaints should be processed promptly and fairly with communication of progress. Final response should be given in writing within a reasonable period of time. Further, if policyholder/claimant/beneficiary is dissatisfied with the final response given by the insurer, he should be informed if interested to activate an internal appeals process or appeal to the dispute settlement

procedure available outside the company (OECD, 2004).

Claim Recoveries: although this process does not involve the policyholder, an insurer may require recovering all or part of their outlay. There are four sources of recovery; from a third party who was to blame for the accident, from a party insurer has subrogation rights against, from a reinsurer if reinsurance protection is in place or from sale of salvage.

The insurance policy is a document containing a pledge by the insurer that it will indemnify the insured, subject to specified terms, conditions and exceptions of the insurance, against loss or damage which may be sustained or liability which may be incurred at some future time (Wanner, 2011). Therefore, the insurer's efficiency in claims handling and his ability to honor the promise made in the policy document should the need arise may do more to improve or damage the insurer's reputation than the underwriting, marketing and the accounts departments put together.

In fact, it has been said that an insurer's best form of advertisement is the way in which he deals with claims. Certainly a policyholder is more likely to remain loyal to the insurer who deals with his claim in a reasonable manner. Similarly, it may be argued that a satisfied third party is equally an excellent advertisement for an insurer (Wanner, 2011). No claim is maintainable under a policy of insurance unless all the conditions precedent and subsequent to the contract and conditions precedent to liability have been met (Wanner, 2011).

The claim procedure manual of Tsehay Insurance S.C., as cited in Wanner (2011), is highlighted below:

A. Insured's Duties

In the event of an occurrence likely to lead to a claim under a policy, there are certain implied or unwritten duties and certain express or written duties imposed on the insured.

i. Express Duties

These duties require the insured:

a. To notify the insurer of any event which could give rise to a claim under the policy for investigation of the circumstances and to provide full particulars of the claim relating to the insured, the subject matter insured and details of the loss within a stipulated period which is 5 days in the Ethiopian commercial code.
b. Not to use fraudulent means to obtain benefit under the policy.
c. To allow the insurer to exercise subrogation rights if requested to do so (he must not do anything to prejudice those rights).

ii. Proof of Loss

The onus is on the insured to prove:

a. That he suffered a loss due to an event against which is insured.
b. The value or amount of that loss. (If the insurers wish to rely on some exclusion in the policy, the onus is on them to prove that the exclusion applies).

B. Insured's Rights

The insured has the right that, if he complies with all his duties, he is entitled to a full settlement within the terms of the policy. This settlement must be speedily

made and cannot be held up pending recovery of subrogation rights or contribution rights under a market agreement.

C. Insurer's Duties

The insurer must honor the rights of the insured so long as he has complied reasonably with regard to his obligations.

D. Insurer's Rights

In view of their financial interest, the insurers have the right jointly with the insured, to save the subject matter of insurance. This is usually done through the action of loss adjusters.

E. Claim Forms

Insurers use claim forms to gather the information relevant to assessing claims.

The purpose of claim form is fourfold

a. To establish whether the policyholder is entitled to indemnity under his policy
b. To provide sufficient information to process the claim
c. To ascertain whether there is likely to be a claim from the third party
d. To assess and establish the potential cost of the claim

In general terms the questions ask for details of the insured, the property lost, damaged or destroyed, the party injured, and details of how the loss came about, as appropriate. The questions help to seek the information required to assess whether the circumstances of the loss fall within the policy cover, and if so, what the severity of the loss may be.

The answers given on the claim form are checked against the information given at the proposal stage. In this way non-disclosure or misrepresentation often comes to

light, allowing the insurer to avoid liability if they so wish, provided the breach of utmost good faith is material to the loss.

2.1.8 The Nigerian Insurance Sector

In Nigeria, the National Insurance Commission grants license and fully approve the services of the insurance company either as a Life Assurer, Non-Life insurance insurer, or a composite (insurer who carries out both Life and Non-Life Business). Most insurance services in Nigeria are provided by private corporations, but some are provided by the government. For example, in Nigeria, the National Insurance Company of Nigeria (NICON) was established by the federal government to provide insurance services to individuals, banks, establishments and parastatals as well as government-owned insurances; though it has been privatized, yet is still undergoing the same service to the government and general public. Private insurance firms are those currently being studied (Nebo & Okolo, 2016).

The insurance sector is expected to be a major composite of the financial sector in Nigeria. The sector is supposed to mitigate or provide a relief to the effects of exogenous variables such as illness, accident, death, fire, natural disaster, burglary for which we have no control. Because it manages, diversifies and absorbs the risks of individuals and companies, insurance in Nigeria is supposed to be a precondition for the development of other productive activities such as agriculture, manufacturing, construction, building, commerce, transportation and services. The aggregate impact of insurance in a society is to level consumption pattern as a result of its contribution to the financial and social stability of individuals and companies

(Nebo & Okolo, 2016).

The insurance sector has not performed as expected. It has witnessed persistent turbulent periods since its evolution in Nigeria; showing that Nigerians and even the regulatory body are yet to come to terms with the sector's problems. In fact, empirical evidence shows that the insurance sector in Nigeria is characterized by its inability to attract sufficient businesses both locally and internationally. The sector is very weak in retaining a significant proportion of risk emanating from assets domiciled in Nigeria. Premium flight was another key challenge of the sector as the underwriting capability of the existing insurance firms was low compared to the available risks (Ighomirenghian, 2010; Johri, 2009).

In order to provide solutions to the seemingly problems of the insurance industry, the federal government of Nigeria has undertaken some measures to strengthen the sector. First, it empowers the National Insurance Commission (NAICOM) through the National Insurance Commission Act of 1997 and the Insurance Act of 2003 to regulate the activities of all insurance companies in Nigeria by issuing of laws, policies, rules and sanctions that guide actions in the industry. In fact, no insurance firm is authorized to do business in Nigeria unless fully registered and licensed by NAICOM.

Secondly, the industry has undergone two rounds of recapitalization over the past thirteen (13) years. The first was in 2003 when the insurance industry were required to raise their capital bases from N20 million to N150 million for life businesses, N70 million to N300 million for non-life businesses and N150 million to N350 million for reinsurance businesses. Prior to this recapitalization exercises in

December, 2002, there were 117 insurance companies of which 14 were liquidated after the recapitalization exercise as they were unable to scale through the requirement for the exercise. The second recapitalization exercise was in September, 2005. The capital base of the operators was increased from N150 million to N2 billion for Life Insurance businesses. N300 million to N3 billion for Non-Life businesses and N350 million to N10 billion for the Re-insurance companies. After the recapitalization exercise the industry witness a sharp drop in the number of insurance firms by 52.4% from 103 in 2003 to 49 companies in 2005 (Obasi, 2010; Ogbonna, 2013). Thus the double recapitalization exercises were expected to significantly reduce the number of operators, increase competition and standard among existing players in the industry.

Based on the audited financial results, the number of insurance firms as at December, 2014 stood at 60; made up of 16 Specialist Life Insurance companies, 7 Composite Insurance firms, 31 Specialist General Insurance companies, and 2 Re-insurance companies. Despite the reforms by the federal government of Nigeria, the ratio of premium income to the country's GDP is just 1% as at 2013. In spite of its growing population and as the giant of Africa, it is still lagging behind seriously in the world's global ranking. Nigeria occupies the 6th position in Africa and 65th in the global insurance market (UNDP, 2003, Tajudeen 2009; Thomas, 2010) which is a far cry from its potentials.

The argument for the persistent poor performance of the sector still weaves around poor developed distribution channels as a result of brokers interference, poor public perception, unwillingness to pay claims as at when due, lack of requisite skills to

participate in highly specialized transactions, inability to attract and retain skilled talents, inability to adjust to new information and communication technology, low investment and asset management capabilities and poor regulatory oversight (Igbomirenghian, 2010). Others are existence of many fringe operators, unethical practices, dearth of professional human capital and technology; poor asset quality, nonenforcement of compulsory insurance; corporate governance issues, insurance premium flight, lack of innovation in product development; high level of consumer's ignorance of the advantages of insurance products.

.1.9 Challenges in Management of Insurance Claims

A challenge can be described as a difficult task that tests a person's ability and skills (Hornby, 2005). In terms of claims management, a challenge may be described as a factor that hinders effective performance of the claims function. Some of the major challenges in management of general insurance claims are:

Insurance Fraud: Fraud is defined as a deliberate act done with intent to deceive (Cockerell, 1997). A claim is said to be fraudulent if the insured makes false statements of fact in his claim or made statements, knowing them to be false, or not believing them to be true, or that he made them carelessly not caring whether they were true or false. The insurer has a right to decline a claim if fraud is proved, as it amounts to breach of one of the basic principles of insurance, the principle of Utmost Good Faith (Bennett, 1992). Wedge and Handley (2003), note that fraud can take a variety of forms, including the inflation of a genuine claim, creating an entirely fictitious event, and causing deliberate as opposed to accidental damage to

insured property. The main motive of insurance fraud is financial gain.

Insurance companies have had to undergo very tough times and incur huge payouts in claims, some of which have proved to be fraudulent. This has forced insurance companies to rethink the way they handle claims (Karau, 2008). Fraud is perpetrated by a cartel of crooks, through non-existent or exaggerated claims. Fraud has been cited as one of the causes of the collapse insurance companies in the last decade (Wahome, 2010). As much as genuine customers need to be paid promptly, they must be separated from the fraudulent ones through investigations, which is time consuming and a major cause of customer dissatisfaction. If a fraudulent claim is paid, the insurer loses a lot of money to fraudsters. The insurer may resort to increasing premiums, which affects both the good and bad customers. In addition, if a fraudster gets away with it, he may be tempted to continue this practice in the future (Roff, 2004).

Cash Flow Constraints: Cash flow management is the process of monitoring, reviewing and regulating a company's cash flows. The statement of cash flows reports a company's cash inflows and outflows for a period and provides a company's ability to generate cash from operations, maintain and expand its operating capacity, meet its financial obligations and pay dividends (Reeve, Warren & Duchac, 2009). For a general insurance company, cash inflows include premium, investment income, capital injections, policy excess, sale of salvages and reinsurance recoveries. Cash outflows include claim payouts, costs, investments made in shares/bonds, distribution payments to owners and creditors of the insurer,

tax to the government and payment of reinsurance premiums (General Insurance, 2010).

A company may experience cash flow constraints due to various reasons, including outstanding premiums, competing priorities, failure or delay of reinsurers to pay their share of claims, huge claims among others. Claims payment usually takes the largest percentage of a company's payments, and the one affected most when a company has cash flow constraints. If a company has cash flow constraints, the item likely to be affected most is claims payments. Failure or delay in meeting financial obligations when they fall due negatively may affect a company's reputation.

Capacity of Claims Personnel: In a service industry such as insurance, contact employees are the face of the organization, and can directly influence customer satisfaction (Zeithaml & Bitner, 2003). Employees in Claims Department 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). Further, the best defenses against claim fraud are well-trained Claims staff. The process of uncovering and battling fraud begins in the Claims Department (Brown, 1997).

It is the responsibility of the Claims Manager to recruit, train and retain intelligent and competent staff. He should also delegate responsibilities within the department in a way that whereas a substantial proportion of claim advices do not have to be referred to his office, decisions with serious ramifications on the business are not left to inexperienced or incompetent staff (Wedge & Handley, 2003).

However, due to various factors, some of which are not within the manager's control, claims staff leave employment and have to be replaced. Whereas direct costs associated with loss and replacement of employees is measurable, there are also indirect costs associated with loss of employees, including loss in customer service and customer satisfaction. The company also suffers loss of specific job skills and disruption of service (Mwangi, 2008). If the insurance company is not an attractive employer, retention of competent and qualified staff may be a major challenge.

Information Technology Support: Information Technology (IT) is defined as the use or production of a range of technologies (especially computer systems, digital electronic and telecommunications) to store, process and transmit information) (Wedge & Handley, 2003). Claims managers need to maximize the use of information technology, in order to reduce claims processing cycle, thus enhancing efficiency and customer satisfaction. Ineffective IT governance and control is likely to be the main cause of the negative experiences many organizations and especially insurance firms have had with the use of IT, including lost business, damaged reputations, weakened competitive position, inability to meet deadlines, failed or aborted projects, budget overruns and poor returns on investments (Nyakomitta, 2009).

Large complex claims, especially liability claims may take long to be concluded. Besides, they may involve a lot of correspondence between the insurance company and claimant and/or the claimant's advocate. For such claims, there may be a lot of manual intervention, and the IT system may not be flexible enough to capture all the

intricacies of the claims. Further, general insurance claims are paper-based to a large extent; therefore, automation may be only partial. In addition, interfaces between insurers and service providers may not be integrated, which may result to poor claims tracking and lack of management information.

Weak Underwriting Standards: 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). The underwriter also has a responsibility to ensure that there is no adverse selection against the insurer, and that the proposer is not a moral hazard. The underwriter must ensure that the premium charged is commensurate with the risk exposure.

To a large extent, the quality of underwriting has a bearing on claims eventually made. Moral hazard proposers and adverse selection are also not detected. Within the insurance period, such proposers lodge claims, which would have been avoided if they were detected at underwriting stage. Unissued policy documents pose a major challenge to a claims handler. The insured feels unjustly treated, if the claims manager relies on breach of a policy condition to decline a claim which policy the insurer had not issued and sent it to the insured. Other challenges include wrongly worded policy documents, incomplete or no proposal forms, agents 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 were done.

Inability to adhere to internationally accepted underwriting standard brings a level

of risk, which leads to charging premium which is less than the risk exposure (Karau, 2008). When the level of claims exceeds premiums received, the insurance company is unable to meet its obligation to policyholders; and this may result to its closure.

2.2 Empirical Studies

As the subject of continued debate in marketing literature, the distinction and association between service quality and customer satisfaction remains at the forefront of many academics and practitioners. Oliver (1993) cited in Yosef (2018), first suggested that service quality would be antecedent to customer satisfaction regardless of whether these constructs were cumulative or transaction - specific. Some researchers have found empirical supports for the view of the point mentioned above. For instance, Munawar (2014), has researched impact of service quality on customer satisfaction and customer loyalty in the banking industry. His findings indicate that service quality and all its dimensions have significant and positive association with customer satisfaction and customer loyalty. Similarly, Qadeer (2013), looked at service quality and customer satisfaction in Nigerian Banking Sector. He found that service quality does affect customer satisfaction by significantly contributing towards it.

Jajaee and Ahmad (2012), assessed the relation between service quality and customer satisfaction in the Australian car insurance industry. As the current study intends to realize the various relations among these variables, the study analysis includes the correlation study between the constructs. For gathering the data, an

online questionnaire was distributed and totally, 384 individuals who reside in the Melbourne, Australia responded the questionnaire. The results indicate that good relationships exist between five service quality dimensions (reliability, empathy, assurance, responsiveness, and tangibility) and customer satisfaction also there is a strong relationship between service quality and customer satisfaction with the correlation coefficient (r^2) =0.866 at the 0.01 level (2-tailed).

Yusuf, Ajemunigbohun and Alli (2017), empirical investigated insurance claims management among selected insurance companies in Nigeria. The study review critically the significant contribution of the claims processing in the management of insurance firms' claims. The study was conducted in Lagos metropolis, by employing a descriptive survey design using random sampling technique and thus gathered data through the use of structured questionnaire. The sample population consisted of 127 respondents made up of claims managers and other members of staff within the surveyed companies. One sample T-test was adopted in the analysis of collected data. Empirical assessment reveal that the various claims handling processing have significant effects in the claims management processes of insurance companies. The study findings confirm the significance of the various claims handling processing in claims management of insurance companies in Nigeria. It therefore recommends that claims manager should put forward strategic plans to ensuring that insurance claims complaint files are properly kept, monitored and handled for needs that may warrant its usefulness in the future. Also, state-of-the-art training mechanism should be put in place to enhance and improve the working pattern of a claim officer which invariably might affect the organizational

efficiency of insurance companies and lastly, Government should harmonize their resources and technical knowhow with the Nigerian insurance industry in ensuring that insurance claims are well designed to curtail fraudulent claims experienced in the past.

Nebo and Okolo (2016), examined the effects of the strategies for customer satisfaction on the performance of selected insurance firms in Enugu Metropolis". The objectives of the study were to determine the strategies mostly adopted by insurance firms in Nigeria for customer satisfaction, to assess how each of the strategies adopted contributes to the performance of the insurance industry in Nigeria and to ascertain the overall effects of these strategies on the performance of the insurance industry in Nigeria. Survey research design was adopted for the study, 20 out of the 49 insurance firms quoted in the Nigerian Stock Exchange (NSE) were selected for study. Convenience sampling method was used for the selection. Data was collected from 20 managers, and 128 customers who have been with the insurance company for over three years. Questionnaire was used for data collection. Chronbach's Alpha method was used for assessing the internal consistency of the questionnaire and the reliability test of the instrument shows 0.83 standard alpha. Principal Component and Multiple Linear Regression tools were used to test the hypotheses formulated for the study. Findings show that out of the 15 strategies studied, ten (10) were mostly adopted for customer satisfaction. Second, out of the ten (10) factors adopted 7 had significant influence on the insurance industry's performance. These are: prompt settlement of claims, quality insurance products, fair premium, prompt attendance to customer complaints, timely communication of

policy renewal notices, thorough explanation of policies, explanation of product benefits and understandable policy documents. Third, the strategies used by insurance firms had a significant influence on the performance of the insurance firms (R2=0.766, P < 0.001 at 5% significance level). The study recommends that managers should capitalize on those seven strategies that have strong positive influence on customer satisfaction to improve the seemingly battered image and performance of the insurance industry in Nigeria while deemphasizing expenditures in money, time and human resources on the less important variables.

Omar (2005), assesses consumers' attitudes towards life insurance patronage in Nigeria and found that there is lack of trust and confidence in the insurance companies. Other major reason he adduced is lack of knowledge about life insurance products. He called for a renewed marketing communication strategy that should be based on creating awareness and informing the consumers of the benefits inherent in life insurance so as to reinforce the purchasing decision. The weakness of Omar's study is his inability to relate demographic variables such as income and religion on consumers' attitude towards insurance services. Standard of living and religion could be some of the demographic factors that influenced the poor attitude of Nigerians towards insurance services. For example, where income per capita is low, insurance penetration is bound to be low.

Ifejionu and Toyosi (2011), evaluated customers' assessment of the quality of insurance services in Nigeria, with the objective of finding how this can be used to boost the demand for insurance which is presently low in Nigeria. Questionnaire was administered to wide spectrum of insurance customers who had insurance

policies in Lagos State, in order to gather information related to their perception of quality. Descriptive analysis such as percentage and table presentations was used to analyze the collected data. The study revealed among other things that prompt claim settlements is the most important factor considered by the customers of insurance companies in Nigeria in their evaluation and measurement of quality of the policies they are holding. The study therefore recommended that the culture of delay in premium payment or non-payment should be stopped and organizations should look inward to see the reasons why the payment of premium is a problem.

In the insurance industry, Siddiqui and Sharma (2010), for example analyzed customer satisfaction with service quality in life insurance services in India. Based on data collected from 868 participants and Structural equation modeling, their research showed service-quality dimensions such as assurance personalized financial planning, competence, corporate image, tangibles and technology influence customer satisfaction with agents, functional services and with company, which, in turn, has an impact on overall satisfaction in life insurance.

Gachau (2015), also tried to examine the impact of service delivery quality on customer satisfaction in Kenyan Insurance Industry. Using a sample of 64 respondents from 16 insurance companies, he found out that those who were dissatisfied with the service offer at the insurance companies cited poor service delivery quality as a reason.

Perera and Gamage (2019), assessed the determinants of service quality affect towards the customer satisfaction and whether there is effect of customer satisfaction on behavioral intention to retain with reference to motor insurance

policy holders in insurance companies in Sri Lanka". The population of the study were the motor insurance policy holders in the Western Province and the sample consisted with 125 motor policy holders selected through random sampling technique. Self-administered structured questionnaire was used to collect the primary data and the data was analyzed using Minitab software and the SPSS software packages to examine the customers" attitudes towards the existing situation of the service quality of the motor insurers and to examine the customer satisfaction and intention behavior to retain with existing company. It was found that, customers neither disagreed nor agreed with the existing situation of the insurers. Further, it was found that, there was strong positive relationship between functional quality dimensions with customer satisfaction, except tangible and assurance dimension which are having moderate positive relationship between the variable. Further, it was found that price, technical quality and image dimensions also having moderately positive relationship with customer satisfaction.

Yusuf and Ajemunigbohun (2015), conducted a study of effectiveness, efficiency, and promptness of claims handling process in the Nigerian insurance industry. Using a sample of 107 respondents drawn from claims department of 33 insurance companies and One Sample T-test, he tested two hypotheses. Their finding indicated that that managing claims effectively and efficiently will significantly affect operational process in claims management and thus, promptness in claims handling processes does essentially assist in fraud detection and prevention.

Asfaw (2008), also conducted a research to assess the impact of service quality on customer satisfaction and loyalty in the Ethiopian Insurance Industry. Using the

SERVPERF scale and a sample of 706 participants, he conducted an inferential analysis. The result of this study showed that, all service quality dimensions (Tangibles, Reliability, Responsiveness, Assurance, and Empathy) have positive and significant impact on customer satisfaction and customer loyalty.

The main reason customers buy insurance policy being risk management, getting payout on claims during an incident accounts for a significant part of the service clients expect from insurers. EY (2010), also claims process is a unique opportunity for insurers to deliver an experience that will allow a positive customer relationship to develop. Customer satisfaction with motor claims has consequent impact on retention rates and brand advocacy EY (2010). In line with this, research have looked at the impact of service quality of the claims management process of motor insurance on customer satisfaction.

Research on the effect of claims management process on customer satisfaction in the motor insurance sector are dominated by white papers and industry analytics rather than peer reviewed research papers. For example, a research commissioned by Central Bank of Ireland to assess the Consumers' Experience of the Motor Insurance Claims Process used quantitative online survey of 284 consumers who had made a motor insurance claim (Central Bank of Ireland, 2017). The research showed that element of the claim management process like the easiness of reporting damage, a single person handling the claim, the amount of settlement and the repair work done as determinants of customers' satisfaction.

Similarly, the J.D. Power 2016 U.S. Auto Claims Satisfaction Study (annual publication) showed that drivers of increase in overall satisfaction level were found

to be availability of multiple communication option to report and follow up claims (Auto Claims Satisfaction Study, 2016). The study also finds that the use of technology to check the status of a claim is relevant for satisfaction. The study also calculated satisfaction on a 1,000-point scale using dimensions of first notice of loss (claim); service interaction; appraisal; repair process; rental experience; and settlement to rank motor insurance service providers. A research conducted by TeleTech to identify what drives customer satisfaction during the insurance claims process, identified initial filing of the claim, use of knowledgeable insurance reps, obtaining approval for the claim, overall effort required to file a claim and initial assignment of the adjustor on the claim as the top reasons for satisfaction (TeleTech, 2015).

EY (2010), conducted pan-European survey of customer satisfaction with motor claims covering motor insurance customers in Belgium, France, Germany, Italy, Netherlands, Spain and Great Britain. Using 700 customers, their findings indicate that insurer's communication capability during all the process of claims management was the main reason for customer's satisfaction. The study also indicated that customers' age, gender and level of income have a minimal effect on their level of satisfaction. Further, the study indicated that strong levels of customer satisfaction can have a very positive effect on loyalty.

2.3 Theoretical Framework

2.3.1 Expectancy Disconfirmation Theory

Later, Oliver (1977), drawing on the adaptation level theory Helson, (1964), developed the Expectancy-Disconfirmation model for the study of consumer satisfaction, which received the widest acceptance among researchers.

Drawing on the shortcomings of the above early theories of consumer satisfaction, Oliver (1977; 1980) proposed the Expectancy-Disconfirmation Paradigm (EDP) as the most promising theoretical framework for the assessment of customer satisfaction. The model implies that consumers purchase goods and services with pre-purchase expectations about the anticipated performance. The expectation level then becomes a standard against which the product is judged. That is, once the product or service has been used, outcomes are compared against expectations. If the outcome matches the expectation confirmation occurs. Disconfirmation occurs where there is a difference between expectations and outcomes.

A customer is either satisfied or dissatisfied as a result of positive or negative difference between expectations and perceptions. Thus, when service performance is better than what the customer had initially expected, there is a positive disconfirmation between expectations and performance which results in satisfaction, while when service performance is as expected, there is a confirmation between expectations and perceptions which results in satisfaction. In contrast, when service performance is not as good as what the customer expected, there is a negative disconfirmation between expectations and perceptions which causes

dissatisfaction.

This type of discrepancy theory has a long history in the satisfaction literature dating back at least to Howard's & Sheth's (1967), definition of satisfaction which states that it is a function of the degree of congruency between aspirations and perceived reality of experiences. Porter (1961) can be credited with early empirical applications of this comparative model of customer satisfaction in the field of job satisfaction (Oliver, 1997).

From the customer side, before a purchase is made, customers form expectations based on past buying experiences, word of mouth, friends and associates' advice, marketers and competitors' information and promises as well as advertising. Customer satisfaction (positive disconfirmation) then occurs when a product performs better than expected. The reverse is the case, when a product performs lower than expected (negative disconfirmation).

In general, satisfaction or dissatisfaction is a person's feelings of pleasure or disappointment resulting from comparing a product's perceived performance or outcome in relation to the person's expectations. Customer satisfaction then is an evaluative process that contrasts pre-purchase expectations with perceptions of performance during and after the consumption experience. It is used to describe how well a company's products match customers' expectations (Baggozi, 2008; Walker, 2004, Boone & Kurtz, 1999). Ogba (2012), explains that customer satisfaction refers to how well customers' hopes are met in a given transaction and is an important cause of customer loyalty. It is also seen as a fundamental concept that best describes the firm's marketing success in every industry (Hunt, Chonko &

Wood, 2005).

Customer satisfaction is a function of customers' perception, customers' expectations and customers' experience (Hartfield & Huseman, 2002; Anderson & Sullivan, 2003; Anderson & Mittal, 2010), which ultimately can lead to customer brand loyalty, firm's improved market share and a differential advantage over competitors (Schiffman & Kanuk, 1987; Anderson & Mittal, 2010). A satisfied customer is likely to be loyal, make repeat purchases and make use of a wide range of services offered by a firm (La Barbera & Mazursky, 1983; Faullant, Matzler & Fuller, 2008; Roshani, 2009). Satisfied customers add value to the organization and spread a positive word of mouth and help in making good reputation of products and the organization. All these are the phenomenological nature and descriptions of a satisfied customer (Ahluwalia, Rao & Brunkrant 2009).

2.3.2 The Dissonance Theory

Early researchers, including Engel, Kollat and Blackwell (1968); Howard and Sheth (1969) and Cardozzo (1965), relied on the dissonance theory developed by Festinger (1957).

The Dissonance Theory states that a person who expected a high-value product and received a low-value product would recognize the disparity and experience a cognitive dissonance (Cardozzo, 1965). That is, the disconfirmed expectations create a state of dissonance or a psychological discomfort (Yi, 1990). According to this theory, the existence of dissonance produces pressures for its reduction, which could be achieved by adjusting the perceived disparity. This theory holds that "post

exposure ratings are primarily a function of the expectation level because the task of recognizing disconfirmation is believed to be psychologically uncomfortable. Thus consumers are posited to perceptually distort expectation-discrepant performance so as to coincide with their prior expectation level" (Oliver, 1977, p. 480). For instance, if a disparity exists between insurance service expectations and service rendered, consumers may have a psychological tension and try to reduce it by changing their perception of the product (Yi, 1990). Cardozzo (1965), argues that consumers may raise their evaluations of those products when the cost of that product to the individual is high. For example, suppose that a customer who insured his/her motor, which she or he expects it to be good, and is confronted with less quality insurance policies. The consumer, who had driven a long distance and paid a high price for the service, in order to reduce the dissonance, might say that the insurance service was not really as bad as it appeared.

Researchers pursued this approach implicitly assume that consumers would generally find that product performance deviated in some respect from their expectations or effort expenditures and that some cognitive repositioning would be required (Oliver, 1980). This theory has not gained much support from researchers, partly because it is not clear whether consumers would engage in such discrepancy adjustments as the model predicts in every consumption situation. In his criticism of the Dissonance theory, Oliver (1977), for instance, argues that "Generally, it is agreed that satisfaction results from a comparison between X, one's expectation, and Y, product performance. Thus, it is the magnitude and direction of this difference, which affects one's post-decision affect level. X serves only to provide

the comparative baseline. Moreover, consumers are under no particular pressure to resolve the X-Y difference. In fact, satisfaction/dissatisfaction is thought to arise from recognition and acknowledgement of dissonance" (p. 206).

If the Dissonance Theory holds true, then insurance companies should strive to raise expectations substantially above the service delivery in order to obtain a higher product evaluation (Yi, 1990). However, the validity of this assumption is questionable. Raising expectations substantially above the product performance and failing to meet these expectations may backfire, as small discrepancies may be largely discounted while large discrepancies may result in a very negative evaluation. This suggestion fails to take into account the concept of "tolerance level". The tolerance level suggests that purchasers are willing to accept a range of performance around a point estimate as long as the range could be reasonably expected. When perceptions of a brand performance, which are close to the norm (initial expectation), are within the latitude of acceptable performance, and then it may be assimilated toward the norm (Woodruff, Ernest & Jenkins, 1983). That is, perceived performance within some interval around a performance norm is likely to be considered equivalent to the norm. However, when the distance from this norm is great enough, that is perceived performance is outside the acceptable zone, then brand performance will be perceived as different from the norm, which, in contrast to this model's assumption, will cause dissatisfaction not a high product evaluation.

2.3.3 The Contrast Theory

Subsequent studies (Anderson, 1973; Olshavsky and Miller, 1972) drew on the assimilation contrast theories proposed by Sheriff and Hovland (1961).

The Contrast Theory suggests the opposite of the Dissonance Theory. According to this theory, when actual product performance falls short of consumer's expectations about the product, the contrast between the expectation and outcome will cause the consumer to exaggerate the disparity (Yi, 1990). The Contrast theory maintains that a customer who receives a product less valuable than expected, will magnify the difference between the product received and the product expected (Cardozzo, 1965). This theory predicts that service delivery below expectations will be rated poorer than it is in reality (Oliver & DeSarbo, 1988). In other words, the Contrast Theory would assume that "outcomes deviating from expectations will cause the subject to favorably or unfavorably react to the disconfirmation experience in that a negative disconfirmation is believed to result in a poor product evaluation, whereas positive disconfirmation should cause the product to be highly appraised" (Oliver, 1977, p. 81). In terms of the above insurance situation illustrated in the first theory, the consumer might say that the insurance company was one of the worst he or she had ever been and the service was unfit for consumer satisfaction.

If the Contrast Theory was applied to an insurance service industry, then the poor service delivery would be worse than simply poor, and good service delivery would be better than a rating of good would suggest (Oliver, 1997). Under the dissonance theory, the opposite effects occur, perceived performance, whether it is less or more favorable than the consumer's expectations, is drawn to the original expectation

level. It is important to note that these theories have been applied and tested in laboratory settings where the customer satisfaction was tightly controlled, situation specific and individually focused. For instance, this study investigated the ability of these theories in predicting customer satisfaction in insurance industry (Cardozzo, 1965), Thus, it is curious whether hypotheses held by these theories could be accepted or rejected when applied in a field survey research study of insurance industry and customer satisfaction (Oh & Parks, 1997). It is, for instance, not clear whether all patronage in insurance company and services delivery in dissonance.

The three theories that best explain customer satisfaction are Expectancy Disconfirmation Theory, Dissonance Theory and The Contrast Theory (Barsky 1992). They are widely accepted theories of consumer behavior though neither addresses the relationship between customer satisfaction and actual level of service delivery. The theoretical aspect of this study was grounded to the above theories.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Research Design

This study is designed as a descriptive research. Research design constitutes the blueprint for the collection, measurement, and analysis of data (Cooper & Schindler, 2014). According to Thyer (2001), a descriptive study is one in which information is collected without changing the environment and it is used to obtain information concerning the current status of the phenomena to describe "what exists" with respect to variables or conditions in a situation.

3.2 Population, Sample and Sampling Technique

The research looks at the effect of the motor insurance claims management process and customers' satisfaction in the Nigerian Insurance Industry. The primary population of the study, therefore, constitutes existing motor insurance customers of the Nigerian Insurance Industry. This research took a sample of those customers to collect data from. Sampling is related with the selection of a subset of individuals from within a population to estimate the characteristics of whole population. The two main advantages of sampling are the faster data collection and lower cost (Singh & Masuku, 2014).

If sampling is chosen, a study must determine which and how many people to interview, which and how many events to observe, or which and how many records to inspect (Cooper & Schindler, 2014). This research based its sample size determination on VanVoorhis and Morgan (2007), paper where their analysis of

understanding power and rules of thumb for determining sample size mention Green (1991), procedures for determining regression sample sizes. The analysis suggests $n > 50 + 8$ m (where m is the number of IVs) for testing the multiple correlation and $n > 104 +$ m for testing individual predictors. Although Green's (1991), formula is more comprehensive, there are two other rules of thumb that could be used. With five or fewer predictors, (this number would include correlations), a researcher can use Harris's (1985), formula for yielding the absolute minimum number of participants. Harris suggests that the number of participants should exceed the number of predictors by at least 50 (i.e., total number of participants equals the number of predictor variables plus 50), a formula much the same as Green mentioned above. For regression equations using six or more predictors, an absolute minimum of 10 participants per predictor variable is appropriate.

Based on the objective, this study has one dependent variable and six independent variable. Accordingly, the research considered Green's (1991), formula for testing predictors which results:

$n = 104 + m$

$104 + 6 = 110$

Where n = sample size

m = no. of predictors

Since obtaining a sampling frame from Nigerian Insurance Industry (a list of all customers) is a challenge, conducting a probability sampling was practically impossible. To this end, a non- probability sampling technique of convenience

sampling (also known as availability sampling) was used. Saunders, et al. (2012), recommend the use of convenience sampling for the purpose of reducing the time and cost required for data collection. Taking four of the biggest Insurance Copanies in the Federal Capital Territory, Abuja-Nigeria, data was collected from customers that are available at branch office during data collection.

3.3 Methods of Data Collection

The study mainly utilized primary data collected from customers using a self-administered questionnaire. However, secondary data regarding the process of motor insurance claim management of the Nigerian Insurance Industry was also collected from the publication on insurance both print and unprinted materials were utilized. A five- point Likert scale questionnaire was designed and aligned with the motor insurance claim management process at the Nigerian Insurance Industry and activities in each of those claim management processes. The questionnaire developed contained two sections. The first sectioned contained four questions related to the customers' demography. The second section however contained thirty questions grouped under the six stages in the claim management process and customers' overall satisfaction.

Validity and Reliability

In order to assure the validity of the questionnaire, pilot testing, as well as feedback from practitioners at the Nigerian Insurance Industry was done. Nigerian Insurance Industry staff first gave their confirmation that the questions included were representative of the practice. Then ten questionnaires were distributed to customers

to see the clarity of the questionnaire before distributing it to the whole participants. Further, Cronbach's alpha was calculated for the scale to determine reliability (internal consistency). The result of the reliability analysis done using SPSS 23.0 shows that all the seven sub-scales had an alpha of more than 0.8 (table 3.1) which is acceptable according to Tavakol and Dennick (2011).

Table 3.1: Test of Scale Reliability

S./N	Item	Cronbach's Alpha	N of Items
1	Claim Reporting	.871	6
2	Response to Claim	.938	2
3	Damaged Vehicle Towing	.943	4
4	Damage Assessment	.835	4
5	Repair Handling	.827	7
6	Complaints and Dispute Settlement	.968	4
7	Customer Satisfaction	.874	3

3.4 Technique for Data Analysis

The data collected from the respondents using the survey questionnaire was basically a quantitative data. Descriptive statistics, particularly tabular method of data presentation, was used to characterize the respondent's demography. Further, descriptive statistics, particularly mean and standard deviation were used to present

customers' opinion on the claim management process and their overall satisfaction.

Inferential statistics such as correlation and regression were also used to deduce relationship between the dependent and independent variables as well as develop a model for prediction customer's satisfaction on claim management process based on the different elements of the process.

Pearson correlation coefficient was calculated to measure of the direction and degree of relationship between variables. Pearson correlation coefficient could range from -1 to +1, where a result closer to +1 indicates a strong positive relationship while a closer to - 1value could indicate a strong negative relationship.

On the other hand, multiple regression was used to determine the overall fit (variance explained) of the model and the relative contribution of each of the predictors to the total variance explained. The dependent variable was customers' satisfaction while the independent variables included claim-reporting, response to a claim, damaged vehicle towing, damage assessment, repair handling as well as complaints and dispute settlement. Accordingly, the model specification is therefore as follows:

$$Y= \beta 0+ \beta 1x1 + \beta 2X2+ \beta 3X3+ \beta 4x4+ \beta 5X5+ \beta 6X6$$

Where: Y= Customer Satisfaction βo = Constant term

CHAPTER FOUR

DATA ANALYSIS AND RESULTS

4.1 Data Presentation

The research used a survey questionnaire that was distributed to 110 participants. Of those respondents, 102 of them were able to completely filled their questionnaires which were retrieved and used for this study, resulting in 92.7% response rate of distributed questionnaires.

Demographic Variables

Table 4.1: Demographic Profile of Participants

S. No.	Item		Frequency	Percent
1	**Gender**	Male	78	76.5%
		Female	24	23.5%
			102	**100%**
2	**Age**	18-25	11	10.8%
		26-30	17	16.7%
		31-35	23	22.5%
		36-40	24	23.5%
		>40	27	26.5%
			102	**100%**
3	**Education**	Diploma	22	21.6%
		Degree	70	68.6%
		Post Graduate	10	9.8%

			102	**100%**
		< two years	10	9.8%
		2-4 years	15	14.7%
	Tenure with	4-6 years	18	17.6%
4	**Nigerian Insurance**	6-8 years	22	21.6%
	Industry	> 8 years	37	36.3%
		Total	**102**	**100%**

Source: Field Survey (2020)

Section one of the survey questionnaire included four questions related to the demographic profile of the participants. Table 4.1, shows the summarized demographic profile of the participants. It can be observed from the table that the majority of participants were male constituting 76.5% where only 23.5% were female. In terms of age, customers with age group above 40 were the largest at 26.5%, closely followed by the age group 36-40 with 23.5% and 31-35 with 22.5%. The other two age groups 26-30 and 18-25 covered 16.7% and 10.8% of the participants respectively.

Looking at the level of education of customers who participated in the survey, one can notice that it on covered those with a diploma, a degree of a postgraduate level education. Those with degree level of education were the significantly larger group containing 68.6% of the participants followed by diploma level education with 21.6%. The third group postgraduate level of education covered only 9.8% of the participants. The factor that the survey was a self-administered questionnaire might have limited the participation of groups of customers with no education.

The customers' tenure with the Nigerian Insurance Industry shows that, the majority, 36.3% have stayed with Nigerian Insurance Industry for more than eight years. Those who stayed with the Nigerian Insurance Industry as a customer from 6-8 years were 21.6% and those with 4-6 years stay were 17.6%. This means that more than 75% of the participants have been with the Nigerian Insurance Industry for more than four years or more. It only 14.7% who stayed with the Nigerian Insurance Industry between 2-4 years and only 9.8% who stayed of less than two years.

Descriptive Statistics

The claim management process at Nigerian Insurance Industry mainly constitutes five stages claim reporting, response to a claim, towing damaged vehicle, damage assessment, and repair handling with one further potential phase complaint and dispute settlement if the customer lodges complaint or raises a dispute. The second section of the survey questionnaire constituted twenty-seven questions grouped into the above six stages in the claim management process as well as three additional questions measuring the customers' overall satisfaction. The table 4.2, presents the descriptive statistics for each of the variables, particularly their mean and standard deviation.

Table 4.2: Descriptive statistics of variables

S/N	Variables	Mean	Std. Deviation
1	Claim reporting	3.61	0.97
2	Response to claim	3.16	1.26
3	Damaged vehicle towing	2.36	1.27
4	Damage assessment	2.93	0.98
5	Repair handling	2.93	0.90
6	Complaints and dispute settlement	2.46	1.31
7	Overall satisfaction	2.88	0.97

Source: Field Survey (2020)

The customers response to claim management processes claim reporting and response to claim have a mean value of slightly higher (3.61 and 3.16) than the neutral value three merely suggesting their agreement those processes were acceptable to them. On the other two stages of the claim management process, namely damage assessment and repair handling had the same mean value 2.93 again a very close value to the neutral value three but below it which could indicate a degree the customer disagreement that the processes were handled acceptably. The standard deviation for both were below one (0.98 and 0.90) suggesting a higher level of agreement between participants. For damaged vehicle towing 'and complaints and dispute settlement, the mean values were 2.36 and 2.46 showing customers disagreement that the processes were handled acceptably. However, the standard deviation for both are above one (1.27 and 1.31) showing a higher level of variability in participants response. The mean value of the overall satisfaction is 2.88 with sd 0.97. This value is close to the neutral value three, which represents

acceptable rather than the value two that represented poor.

4.2 Data Analysis and Results

Pearson correlation was calculated to see the relationship between the dependent variable overall satisfaction and the independent variables claim reporting, response to a claim, damaged vehicle towing, damage assessment, repair handling as well as complaints and dispute settlement. All the independent variables showed correlation with the dependent variable. In their order of strength of relationship repair handling was strongly correlated to satisfaction with Pearson correlation coefficient r (102) = 0.783, $p < .01$, followed by damage assessment with r (102) = 0.745, $p < .01$. Third was complaint and dispute settlement with r (102) = 0.705, $p < .01$. Vehicle towing and claim reporting were fourth and fifth with r (102) = 0.632, $p < .01$ and r (102) = 0.540, $p < .01$ respectively. The last variable response to claim had a week positive relationship with satisfaction but a lesser degree of significance (r (102) = 0.205, $p < .05$.

Table 4.3: Correlation Coefficient

Correlations

		Claim Reporting	Response to Claim	Vehicle Towing	Damage Assessment	Repair Handling	Complaint Settlement
Overall Satisfaction	Pearson Correlation	.540**	.205*	.632**	.745**	.783**	.705**
	Sig. (2-tailed)	.000	.038	.000	.000	.000	.000
	N	102	102	102	102	102	102

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

Source: SPSS Outcome (2020)

A standard multiple regression analysis was conducted to evaluate how well the different elements of the claim management process particularly claim reporting, response to a claim, damaged vehicle towing, damage assessment, repair handling as well as complaints and dispute settlement predicted overall satisfaction of customers.

Table 4.4: Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.843[a]	.711	.693	.53796

a. Predictors: (Constant), Complaint, Response, Towing, Reporting, Assessment, Repair

b. Dependent Variable: Satisfaction

Table 4.5: ANOVA

Model		Sum of Squares	Df	Mean Square	F	Sig.
1	Regression	67.571	6	11.262	38.914	.000[b]
	Residual	27.493	95	.289		
	Total	95.064	101			

a. Dependent Variable: Satisfaction

b. Predictors: (Constant), Complaint, Response, Towing, Reporting, Assessment, Repair

The multiple linear regression of the dependent variable (overall satisfaction) and the independent variables (claim reporting, response to a claim, damaged vehicle towing, damage assessment, repair handling as well as complaints and dispute settlement) resulted in a significantly related equation with $F((6,95) = 38.914$, $p < .001$. The multiple correlation coefficient was 0.843, indicating that approximately 71.1% of the variance in satisfaction can be accounted for by the linear combination

of factors claim reporting, response to a claim, damaged vehicle towing, damage assessment, repair handling as well as complaints and dispute settlement.

Table 4.6: Coefficients

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	-.031	.238		-.130	.897
	Reporting	.147	.095	.147	1.553	.124
	Response	.046	.063	.060	.734	.465
	Towing	.026	.066	.034	.397	.692
	Assessment	.270	.100	.271	2.687	.009
	Repair	.341	.111	.316	3.055	.003
	Complaint	.156	.065	.211	2.380	.019

Source: SPSS Outcome (2020)

The multiple linear regression also showed that the independent variables damage assessment and repair handling were significant at $p < 0.01$ while complaint and dispute settlement was significant at $p < 0.05$. The other three predictors claim reporting, response to claim and damaged vehicle towing were not found to be statistically significant at $p < 0.05$. The regression equation for predicting overall satisfaction is therefore:

Predicted Satisfaction = - 0.031 + 0.147 [Claim Reporting] + 0.046 [Response to claim] + 0.026 [Vehicle Towing]

Lastly, test of basic assumptions in multiple regression was done. Test of non-linearity was done using a scatter plot of the standardized predicted value with the standardized residuals. From the Loess curve, it appears that the relationship of standardized predicted to residuals is roughly linear around zero (see annex B for detail). Therefore, it was concluded that the relationship between the response variable and predictors is zero since the residuals seem to be randomly scattered around zero. Similarly, the scatter plot was also used to test the homogeneity of variance which showed the trend is centered around zero but also that the variance around zero is scattered uniformly and randomly. We conclude that the linearity assumption is satisfied and the heteroscedasticity assumption was satisfied.

Multicollinearity effect in the multiple linear regression model was also checked. The detailed coefficients table (annex B) shows that Tolerance value for all predictors was > 0.1 and VIF< 10. Lastly, normality of residuals was checked using a normal P-P plot. The plot shows that the points generally follow the normal (diagonal) line with no strong deviations. This indicates that the residuals are normally distributed. Accordingly, it can be concluded that the regression model developed satisfies the basic assumption in regression.

4.3 Discussion of Findings

As mentioned at various points, the claim management process at Nigerian Insurance Industry included five elements or stages, which are claim-reporting, response to a claim, damaged vehicle towing, damage assessment and repair handling. A sixth potential process involves complaints and dispute settlement process for those clients with any kind of grievances. Although, there was a shortage of similar research to compare this with industry researches in Europe and North America show that the claim management process elsewhere involves third parties like agents and brokers as well as digital technologies (online, Smartphone, tablet, web or others) during the claims process (EY,2010; Accenture, 2014). The findings above show that customers overall satisfaction with motor insurance claim management is close to acceptable (a mean value of 2.88 and sd of 0.97). This in contrast, is much lower than European customers experience of making a motor insurance claim is, on average, extremely positive (EY, 2010).

Further, inferential statistics showed that all the six processes or elements have a positive correlation with overall satisfaction with claim reporting (0.540), damaged vehicle towing (0.632), damage assessment (0.745), repair handling (0.783) and complaint settlement (0.705) with $p< 0.01$while response to a claim (0.205) with $p< 0.05$. In line with this, the regression model developed to predict customer satisfaction showed that a statistically significant linear model using the independent variables was possible. The model also showed that the predictors repair handling with coefficient 0.341 and damage assessment with coefficient 0.270 were the highest predictors of satisfaction with $p<0.01$ followed by complaint

and dispute settlement with coefficient 0.156 ($p<0.05$). The regression model also showed that the predictive ability of element of claim management like claim reporting with coefficient 0.147, response to claim with coefficient 0.046 and vehicle towing with coefficient 0.026 where all three were insignificant.

Improving motor insurance claim management process could improve the overall customer satisfaction which can also translate into policy renewals. Prioritizing and improving elements of the motor insurance claim management process specifically repair handling and damage assessment followed by complaint and dispute settlement should result in higher level of customer satisfaction quickly. The other three elements of the motor claim management processes; namely claim reporting, response to a claim and damaged vehicle towing were not seen as strong predictors of satisfaction. However, this does not mean that these processes irrelevant rather their improvement could enhance the subsequent processes as their outcome serves as an input for the subsequent processes

As agreed with the findings of this study, Yoseph (2014), revealed that claim settlement service is the basis on which an insurance company is ultimately judged by clients and the key issue affecting the reputation of the insurance company. For many insurance companies, fast claim settlement service is considered to be a differentiator that distinguishes them from the competitors. Claim settlement service is the basis on which an insurance company is ultimately judged by clients and the key issue affecting the reputation of the insurance company. Indeed, for many insurance companies, excellent claim settlement service is considered to be a differentiator that distinguishes them from the competitors and hence achieving excellence in claim settlement should be a fundamental objective of any insurance company.

According to Perera and Gamage (2019), motor insurance plays a significant role in providing the insurance cover to the road vehicles and becoming an essential aspect of the daily life. Particularly the third party motor insurance provides the cover against third party bodily injuries, deaths and property damages caused by the motor vehicles and the comprehensive motor insurance policy provides the cover to the own damage of the vehicle, along with the third party cover. At present there is a keen competition among the insurance companies to attract and retain more customers and increase their market share in motor insurance. Hence, service quality and customer satisfaction are very important aspects that companies must understand in order to remain competitive in business and grow. It is very important for companies to know, how to measure these constructs from the customers" perspective in order to better understand their needs and satisfy them.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATION

5.1 Summary

This study begun with the aim of assessing the effect of motor insurance claims management process on customer satisfaction in the Nigerian Insurance Industry. Specifically, the research tried to examine the effect of each stage (element) of the claim management process on customer satisfaction. In line with that, the findings can be summarized as follows:

Customers rating of the current claim reporting process resulted in a mean of 3.61 and sd of 0.97. claim reporting was also found to be significantly correlated to customer satisfaction with a Pearson correlated coefficient of 0.540 at $p< 0.01$.

Response to a claim had a mean of 3.16 and sd 1.26. It was also found to be significantly correlated to customer satisfaction with a Pearson correlated coefficient of 0.205 at $p< 0.05$.

The mean value for customers rating of damaged vehicle towing was found to be 2.36 with sd of 1.27 which was also significantly correlated to customer satisfaction with a Pearson correlated coefficient of 0.632at $p< 0.01$.

Customers' rating of damage assessment had a mean value of 2.93 with sd of 0.98. the correlation analysis also showed that it was significantly correlated to customer satisfaction with a Pearson correlated coefficient of 0.745at $p< 0.01$

The mean value of repair handling as rated by customers was 2.93with sd of 0.90. the correlation analysis also showed that it is significantly correlated to customer satisfaction with a Pearson correlated coefficient of 0.783 at $p< 0.01$.

Complaint and dispute settlement was given a mean of 2.46 by customers with sd = 1.31. It was further found to be significantly correlated to customer satisfaction with a Pearson correlated coefficient of 0.705 with $p< 0.01$

The multiple linear regression model calculated to predict customer satisfaction based on elements of the claim management process was significant with $F((6,95) = 38.914, p < 0.001)$, with an R^2 of 0.843.

Regarding the customer satisfaction, the mean value of 2.88 and sd of 0.97 suggest that that customers' overall satisfaction with motor insurance claim management is close to the neutral value three representing acceptable level.

5.2 Conclusion

The study assessed the effect of motor insurance claim management process and customer's satisfaction in the Nigerian Insurance Industry. In light of the analysis done and the summary presented above, the following encompassing conclusions are given:

Both the correlation analysis as well as the multiple regression model have indicated that customer satisfaction is positively related to all the elements of the claim management process. Specifically, repair handling showed the strongest correlation as well as the highest coefficient in the regression analysis leading to the conclusion that repair handling is the most important element of the motor insurance claim management handling process to customers.

This if followed by damage assessment and complaint and dispute settlement processes, which were observed to be the second and third important element of the

motor insurance claim management process with the respectively highest correlation and regression coefficients. The other three elements of the claim management process were seen to have positive relationship with customers' satisfaction however were not found out to be statistically significant predictors of customer satisfaction.

Based on the result of the multiple regression analysis, one can also conclude that the highest drivers of customer satisfaction are the claim management process with direct impact on the monetary value of the claim (damage assessment, repair handling, and complaints and dispute settlement) as opposed to the feel-good elements of the claim process (claim reporting, response to claim and towing).

Regarding the current level of overall satisfaction, a mean value of three representing an acceptable level found. Given the current level of competition in the motor insurance industry in Nigeria, a mediocre level of customer satisfaction is unacceptable by any standards.

5.3 Recommendations

The following recommendations were put forward based on the study's findings:

1. Insurance companies need to distribute its branches and contact address to reach the customers. So that customers will not find it difficult in reporting and getting attended to within short time of report of incident.
2. Insurance companies should take a quick measure regarding this aspect of claim management. It is not to say that all claims must be accepted; rather if a claim is rejected, the right reasons must be clearly given for the claimants. On the other hand, if claims are justified long process and special rules must

be avoided since claimants need a timely & quick compensation that can a healing of their wounded bones by their accidental loss.

3. To increase customers' satisfaction on claim the insurance companies should invest to give training to all concerned underwriters how can underwriters give a necessary information for customers about the policy documents and to help in filling proposal form. In this regard, the company it ought to decide who should receive the training and which training methods will work best. Moreover, the company must also allow up the effectiveness of trained workers.
4. Insurers must continually examine customer satisfaction to identify the factors that are important from a customer perspective and thus to prioritize the most important factors in the success of the insurance industry.
5. Insurance companies need to be too strong & create opportunity to disseminate insurance awareness among the public.

5.4 Limitations of the Study

The main limitations of this study was constraints of resources, access to information, and time. The study covers only four companies in the industry, which limits its generalizability to the industry. The study intends to answer these questions considering more than four (4) companies of this industry. Even though it might not necessarily be representative of the industry, the study also considers it as building preliminary ideas about the customers' satisfaction with the motor insurance claims management of the Nigerian Insurance Industry.

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