International Journal of Economics, Commerce and Management
United Kingdom ISSN 2348 0386 Vol. X, Issue 3, March 2022

http://ijecm.co.uk/

LOSS ADJUSTERS AND INSURANCE CUSTOMERS RETENTION IN THE NIGERIA INSURANCE INDUSTRY

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Abstract

The study sought to determine the role of Loss adjusters on Customers Retention in the Nigeria Insurance Industry. The study employed a survey method and sample of six hundred and forty-five(n=645) customers and adjusters from the total number of (N=2520) customers who have records of loss and the adjusters with a valid license. Data were collected using adopted self-administered questionnaires. Out of six hundred and forty-five questionnaires equally administered among the customers and adjusters, three hundred from each were fully recovered. The four hypotheses tested using chi-square analysis and the findings revealed that Loss adjusters` competency has a significant impact on customers` retention; and that Loss adjusters` reports have a significant effect on claims managers` decisions. The results also showed that Reports time-frame and loss adjusters` work-load have a significant effect on customers` retention; and that Loss adjusters` investigation has a significant effect on customers` retention in the Nigerian Insurance Industry. It was, therefore, concluded that most insurers in Nigeria, according to their clients have unfair claim settlements, The issues of not fully satisfying the customers rest upon the fact that managements do rely upon the information or the investigation results supplied by their loss adjuster and subject to review by the claims

committee as the case may be. The study recommended that insurance firms should ensure that qualified investigators (loss adjusters) who are not biased are employed to enhance effective and efficient results to engage and retain their customers in the Nigerian insurance industry.

Keywords: Adjusters` competency, Customers retention, Claims managers, Loss adjusters, Nigeria, the insurance industry

INTRODUCTION

Insurance firms as known for risks coverage to the insured usually do not just pay claims to the insured for losses because they could through fraud or exaggerated claims. Moreover, insurers realize that the prompt, fair, and courteous payment of claims is one of the strategies of engaging and retaining clients and remaining competitive in the insurance market. Hence, insurers have special people that investigate claimed losses (Capgemini, 2019). For life insurance companies, they are called claim representatives or benefit representatives. In other classes of insurance, they are called claims adjusters, claims auditors, loss adjusters, or just adjusters (Brooks, Popow, & Hoopes, 2015). Today, it is a common practice that the first person the insured meets after suffering a loss is the adjuster who makes the claims process flow smoothly for the parties (Akintayo, 2018).

The process of settling or denying a claim is called a claim settlement or a loss adjustment. Loss adjustment is most important in property insurance, where losses are usually partial and the amount may be hard to determine. However, adjusters investigate losses by determining the liabilities of the insurers and propose the amount to be paid but in some cases determined by the claim committee as the case may be (Amoroso, & Rebecca, 2019). The proposed claims are highly probabilistic and a great deal of reasoning and brainstorming is required because payments are usually made from insurance reserves which might have a great adverse effect on insurers` capital structures and profitability margin. Actuarially, insurance firms usually estimate and attach their claim settlements (i.e., 5% or 8%) against the level of net premium (i.e., 95% or 92%) as the latter determines the inflows (i.e., reserves and other profits) and expected to be properly monitored (Brooks, Popow, & Hoopes, 2015). However, the significance of claim adjustment is to verify the loss, in respect of which cover is provided by the policy and ensures that payment is prompt and fair. Occasionally, the adjuster provides personal assistance to the insured. Investigations turned in by loss adjusters are necessary to prevent fraud and to reduce exaggerated claims: in essence, to verify the amount of the loss. Fair and prompt payment is required because that is the function of insurance. If

insurance companies could wiggle their way out of most payments, people would not buy insurance, since they could never be sure that they would be paid (Iqbal, Rehman, & Shahzad, 2020).

Furthermore, the insurance companies often give agents draft authority, allowing them to issue payments up to a specified amount to speed up, minimize adjustment expenses, and enhance the policyholder's goodwill (Putra, & Dharma 2017). An insurer wishes to satisfy its customers, but it must also keep its payments for claims at a minimum to be able to charge a competitive price for its insurance. Moreover, state laws generally require fair payments. The insurance contract may stipulate a procedure for resolving a payment dispute. For instance, a home-owners insurance policy may require that both the insured and the insurer obtain independent appraisals of the property. If the appraisals differ by a wide margin, then the appraisers can select an umpire, who will determine which of the appraisals are most accurate (Kim, 2015) If the parties do not agree on an umpire, a court will appoint one. A customer who is unhappy about an insurance settlement has several options. If the claim is not paid because the loss event was deemed not covered by the policy, then the insured can appeal to the state insurance department. If the settlement is deemed inefficient, then the insured must go to arbitration, if stipulated by the insurance contract, or to court to contest the amount. The insured can also file a complaint with the state insurance department, using forms provided by their website (Iqbal, Rehman, & Shahzad, 2020).

In geographic areas where insurance companies have many claims, adjusters are usually employees but where fewer claims exist, the insurers use an independent adjuster or an adjustment bureau to administer investigations to minimize cost and ensure efficiency in delivery. Adjustment bureaus were originally owned by multiple insurance companies to investigate fire losses in distant areas. Because adjustment bureaus represented multiple insurance companies, many more areas will have sufficient claims to make loss adjustments cost-effective (Angima, 2017).

Nowadays, most adjustment bureaus are independent companies that simply sell their services to insurance companies. Adjustment bureaus are also used when a large number of claims are filed at the same time, such as after a flood, hurricane, or earthquake. Note, however, that employees of adjustment bureaus work as agents of the insurance companies that hired them, and as such, represent their interests. When a lot of money is at stake, the insured, usually a business, may hire a public adjuster, who is usually paid a percentage of the settlement: usually, 10% reached with the insurance company (Jacob, 2017)

However, public adjusters are used when claims are complex or to settle in the event of disagreement on the quantum of the claim. The public adjuster investigates and quantifies the

loss and presents evidence of that loss to the insurance company, negotiating with the insurance company to maximize payment to the insured, which will also maximize the public adjuster's compensation, if it is based on a contingent fee. The National Association of Public Insurance Adjusters provides certifications that public adjusters can use to market their services: Certified Professional Public Adjuster (CPPA) and the Senior Professional Public Adjuster (SPPA) (Angim, 2017). A thorough examination must be passed to obtain either of these certifications, to give businesses looking for a public adjuster some confidence in selecting a competent individual.

Research Questions

i. How can Loss adjusters` competency impact customers` retention in the Nigerian Insurance Industry?
ii. What is the effect of loss adjusters` reports on claims managers` decisions in the Nigerian Insurance Industry?
iii. In what way can reports' time-frame and loss adjusters` work-load influence customers` retention in the Nigerian Insurance Industry?
iv. How does loss adjusters` investigation affect customers` retention in the Nigerian Insurance Industry?

Objectives of the Study

The main objective of the study is to examine the impact of loss adjusters on customers` retention in the Nigerian Insurance Industry, while the specific objectives of the study are to:

i. Examine the impact of loss adjusters` competency on customers` retention in the Nigerian Insurance Industry
ii. Determine the effect of loss adjusters` reports on claims managers` decisions in the Nigerian Insurance Industry
iii. Examine the effect of reports time-frame and loss adjusters` work-load on customers` retention in the Nigerian Insurance Industry
iv. Assess the effect of loss adjusters` investigation on customers` retention in the Nigerian Insurance Industry

Hypotheses

$H0_1$: Loss adjusters` competency has no significant impact on customers` retention in the Nigerian Insurance Industry

$H0_2$: Loss adjusters` reports has no significant effect on claims managers` decisions in the Nigerian Insurance Industry

$H0_3$: Reports time-frame and loss adjusters` work-load have no significant effect on customers` retention in the Nigerian Insurance Industry

$H0_4$: Loss adjusters` investigation has no significant effect on customers` retention in the Nigerian Insurance Industry

REVIEW OF RELEVANT LITERATURE

The Claims' Concept

A claim on an insurance policy is a demand on an insurer to fulfill its portion of the promise, committed to while writing the contract with the insured (Jacob, 2017). The claim is a notification to an insurance company that payment of an amount is due under the terms of a policy. An insurance claim, therefore, is a demand by a person or an organization seeking to recover from an insurer for a loss that an insurance policy might cover (Association of Insurance and Risk Managers in Industry and Commerce, 2020) Insurance claims range from straightforward domestic building and contents claims that are settled within days of notification to complex bodily injury claims that remain open for many years (Yusuf, & Dansu, 2020). Insurance claims are a request made by the insured person to the insurer to pay the benefits agreed upon under a defined policy. It is a demand placed by an individual or organization against a loss covered by an insurance policy (Capgemini, 2019). However, claims management is essential to an insurer's success. An insurance claim is an insurance extract in which the insurer undertakes to indemnify the insured against a loss, which may or may not arise at a future date or to pay a certain amount of money in the happening of a certain event. The loss that is insured against is referred to as the insured risk. Being legally valid, insurance is enforceable at law. He further stated that the primary duties of the insured under the insurance contract are to pay the agreed premium and to comply with the terms of the policy while the insurer must comply with his terms and promises under the policy and to pay or settle all genuine claims promptly and equitably (Brooks, & Popow, 2015). A well manageable claim strengthens customer relationships amidst all odds, assists in regulatory compliance and fraud prevention and detection (Jacob, 2017)

Loss or Claim Adjuster

Adjusters investigate losses by determining the liability of the insurance company and the amount of the payment. Because the amount of claims is often not great enough to justify sending a special investigator, insurance companies often give agents draft authority, allowing

them to issue payments up to a specified amount. The advantage of having the agent settle the claim is that it is fast, minimizes adjustment expenses, and enhances the policyholders` goodwill. Loss adjustment is most important in property insurance, where losses are usually partial, and the amount may be hard to determine. Adjusters investigate losses by determining the liabilities of the insurers and propose the quantum but in some cases determined by the claims committee as the case may be (Doherty, Tinic, & Seha, 2016). The proposed claims are highly probabilistic, and a lot of reasoning and brainstorming is required because payments are usually made from insurance reserves which might have a great adverse on insurers` capital structures and profitability margin. Actuarially, insurance firms usually estimate and attach their claim settlements against the level of net premium as the latter determines the inflows (i.e. reserves and other profits) and are expected to be properly monitored. (Brooks, Popow, & Hoopes, 2015) However, the significance of claim adjustment is to verify the loss, the risk covered by the policy, and to ensure that payment is prompt and fair.

Claim Settled or Denied

When presented with a claim, the insurance company either pays the claim or denies it. Most claims are paid, but a few will be denied for cogent reasons: either because the loss did not occur or because it is not covered by the policy. A loss may not be covered because it was excluded, the policy lapsed, the loss was not within the scope of the insurance agreement, or the insured violated a policy condition. There are 4 main steps in processing a claim, which may vary, considering the class of insurance: notice of loss, investigation, proof of loss, and payment or denial of the claim. The steps are:

1st step: Notice of loss

The 1st step in the claim, naturally enough, is to give notice to the insurance company about the occurrence of a loss. Most insurance contracts require that the insured notifies the company either immediately or as soon as possible, so that evidence can be preserved for the investigation. Additionally, the insurance contract may require that the insured also take other steps to gather or preserve evidence of such loss, such as gathering the names and contact information of everyone involved in an accident

2nd Step: Investigation of loss

An investigation determines the existence of a loss covered by the policy, whether policy conditions were met both before and after the loss event, and the quantum of loss. A loss will only be covered by a policy if it occurred within the policy period if the loss was caused by a covered peril, and it satisfies the other conditions of the insurance contract. Whether the policy

was in effect when the loss occurred will be especially important if the insurance was just purchased or if it lapsed.

3rd Step: Proof of loss

In the 3rd step, the policy-holder may be required to file a proof of loss within a specified time, which is a sworn statement that the loss occurred, the circumstances of the loss, whether any other insurance covered the loss, and the quantum of loss.

4th Step Reservation of Rights

Sometimes, whether to pay or deny a claim is not clear. Such may be the case when the insurance contract excludes intentional losses, but whether the insured intentionally caused the loss is not self-evident, and the insurance company must await a court decision regarding the intentionality. However, the insurance company will often pay for the legal defense incurred, because not doing so may incur a larger liability on the insurance company where the insured did not act intentionally. Therefore, the insurer may go ahead and start paying for the defense of the insured but will give adequate notice to the insured of its reservation of rights, indicating that the insurer is not certain that the loss is covered, and that coverage may be denied if later evidence or a court judgment supports the denial of coverage. Without the notice of its reservation of rights, the insurer may be found by the court to have acted in bad faith if it started paying the legal defense of the insured, but later stopped payment, or sought to recoup its payment. To be legally enforceable, a reservation of rights letter must use the words reservation of rights and will typically have the following provisions:

1. Identification of the policy at issue
2. The relevant policy provisions and any terms and conditions that may bar coverage
3. The relevant parts of the complaint
4. The claims that may not be covered, and
5. A clear explanation of:

The insurer's basis for denying coverage

How the defense will be conducted, and give notice:

1. That the insured has the right to hire his defense counsel
2. That the insurer has the right to withdraw from the defense and the right to assert other defenses that may become apparent during the investigation or the court process.
3. Of conflicts of interest between the insurer and the insured
4. Appealing a Claim Settlement or Denial

The Claim Payment Process

Disasters can cause enormous demands to be made on insurance companies' personnel. Sometimes after a major disaster, state officials ask insurance company adjusters to see everyone who has filed a claim before a certain date. When there are a huge number of claims, the deadline may force some to make a rough first estimate. If the first evaluation is not complete, set up an appointment for a second visit. The first check received from the insurance company is often an advance. The on-the-spot settlement can be accepted but if other damage, is later discovered, the claim and file for an additional amount can be reopened. Some insurance companies require filling out and signing a proof of loss form. This formal statement provides details of losses and the amount of money claimed which acts as a legal record. Some companies waive this requirement after a disaster if met with the adjuster, especially if the claim is not complicated.

Theoretical Framework

Relevant theories like stakeholder theory, risk management theory, and corporate demand theory articulate the importance of risk-sharing and transferring in the insurance business. Risk diversification is necessary for the underwriting portfolio of insurance companies; this is used to curtail the annihilation of such companies by taking advantage of the expertise of reinsurance companies in stabilizing the shareholders' return (Kim, 2015). The willingness of a ceding company to purchase reinsurance coverage against the risks it has assumed and the primary insurers are faced with higher business plight because of excessive risk exposures and a high degree of enhanced volatility in their level of cash flows, hence, there is a need to ponder on appropriate risk management for its cover and therefore, have a reinsurance arrangement to remove the risks of insolvency and further lower the cost of expected bankruptcy (Yusuf, & Dansu, 2020).

Review of Empirical Studies

This aspect provides the related literature, the methodology adopted, the techniques, and the conclusion and recommendation. This can be used to validate the evidence on loss adjusters and customers` retentions in the Nigerian Insurance Industry. In Indonesia, a study was determining the role of growth on claim payment as it affected the profitability of life insurance companies from 2019 to 2019. The result from the analysis of static panel regression signifies that claim payments have a significant effect on profitability and that the claim ratio and risk-based capital have a negative significant effect on profitability (Angima, 2017). Analysis of the influence of claims management on the profitability of Life Assurance Companies in Nigeria

was examined using multiple regression techniques. It was discovered that profitability has a negative nexus with loss ratio and net claims but depicts a direct nexus with expense ratio (Yusuf, & Dansu 2020).

Furthermore, net claims and loss ratio have a significant effect and apply frequency percentage and t-test statistics to determine claims fraud associated with homeowner's insurance coverage in the Nigerian insurance industry. The study infers that there is a need for an adequate fraud deterrent where it is desirable to promote a stable, confidence-based, result-oriented, and trustworthy market environment. Also, the government should promote an anti-fraud strategy design that will enhance efficient operation and effective service delivery of the insurance industry (Brooks, Popow, & Hoopes, 2015)

A study was empirically researched in Lagos State, to explore the influence of insurance claims management among selected insurance companies in Nigeria using t-test results, it was revealed that the various claims handling processing have significant effects on the claims management processes of insurance companies (Doherty, Tinic, & Seha, 2016).

Conceptual Model

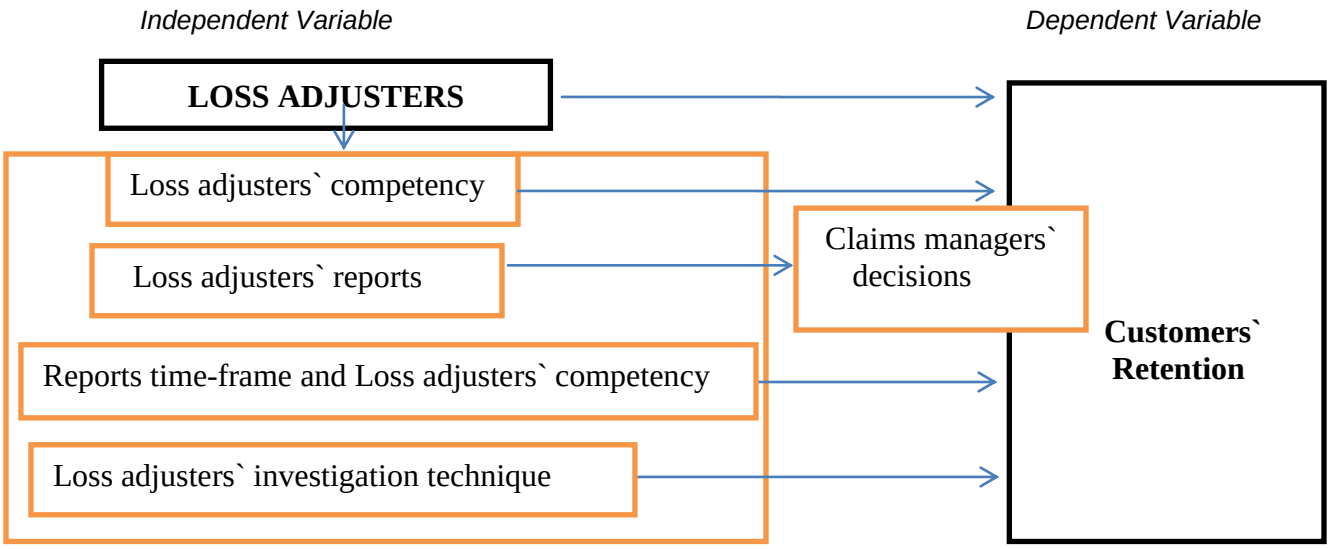

Figure 1 Proposed Conceptual Model

METHODOLOGY

The research design for this study is descriptive design. Research design is defined as a broad plot that strategizes the means used in the collection and analysis of data and this must be harmonized with the objectives of the study. It is a way of organizing educational data and looking at an object to be studied as a whole (Cooper, & Emory, 2019).

Population and Sampling

The population for this study consists of the customers who have records of loss with the Adjusters with the valid license during the time of this study. The total number of customers and the adjusters (N) were two thousand five hundred and twenty in Nigeria, (N = 2,520).

This study adopted the Judgmental/Purposive Sampling technique which is known also, as selective, or subjective, sampling, the use of this sampling technique affords the researchers to make a judgment of who and what to choose as participants on the research from the population The sample size is representing a portion of a population; therefore, the sample must be representative of the population from which they are drawn so that viewed conclusions about the population can be referred to. Hence, six hundred and forty-five (n = 645) customers and adjusters were selected from the population. The sample size was determined through the use of popular technique Taro Yamane (1967) formula given as;

$$n = \frac{N}{1 + N(e)^2}$$

$$n = \frac{2520}{1 + 2520(0.05)^2}$$

$$n = \frac{2520}{1 + 2520(0.0025)}$$

$$n = \frac{2520}{1 + 2.05}$$

$$n = \frac{2520}{3.905}$$

$$n = 645.20547945$$

$$n \approx 645$$

The sample size is approximately 645

Where:

N = Target population

n = sample size

e = sampling error

Method of Data Collection

Data was collected using a structured close-ended pre-coded questionnaire. Questionnaires are data collection instruments enabling the researcher to pose questions to subjects in his/her search for answers to the research questions (Kothari, 2008). The questionnaire was structured in a 5-point Likert scale format. A highly structured question format

allows for the use of closed questions that require the respondent to choose from a predetermined set of responses or scale points.

Data Presentation and Analysis

This aspect focuses on data presentation, analysis, and interpretation concerning the stated objectives and research questions. To obtain the opinion of the customers to arrive at findings, 5-points Likert scale questionnaires were used in collecting information to build up the data. Thus, the data analysis and presentation was thereby divided into two parts. Out of 645 questionnaires administered equally to the customers and adjusters through the Goggle form, 300 from each were fully retrieved. However, the first part of data analysis was descriptive statistics which involved analysis and presentation of customers' bio-data and research questions using frequency and percentage (%) count while the second part of data analysis was inferential statistics which involved a test of hypotheses using Chi-Square correlation analysis with the aid of SPSS software IBM 25.0 version.

FINDINGS

Analysis of Respondent According to Demographic Data

Table 1 Gender

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Male	394	65.7	65.7	65.7
	Female	206	34.3	34.3	100.0
	Total	600	100.0	100.0	

The table 1 shows that more males responded than females. Accordingly, 394 (65.7%) represented male while 206 (34.3%) respondents represented female. This indicates the probability that more males are insured and consequently make more claims than females.

Table 2 Age Group

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	20-30 years	120	20.0	20.0	20.0
	31-41 years	160	26.7	26.7	46.7
	41-51 years	284	47.3	47.3	94.0
	51-61 years	36	6.0	6.0	100.0
	Total	600	100.0	100.0	

Table 2 shows that 20.0% of respondent falls in the age bracket of 20-30 years, 26.7% of respondents fall in the age bracket of 31-41 years, 47.3% of respondents fall in the age bracket of 41-51 years while 6.0% of respondents fall in the age bracket of 51-61 years.

Table 3 Marital Status

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Single	200	33.3	33.3	33.3
	Married	340	56.7	56.7	90.0
	Divorced	40	6.7	6.7	96.7
	Separated	20	3.3	3.3	100.0
	Total	600	100.0	100.0	

Table 3 shows that 33.3% of respondents are not married yet, 56.7% of respondents are married, 6.7% are divorced and 3.3% of respondents are separated. This implies that the majority of the respondents were married.

Table 4 Educational Qualifications

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	SSCE/GCE	32	5.3	5.3	5.3
	OND/NCE	80	13.3	13.3	18.6
	First Degree/HND	140	23.3	23.3	41.9
	Master Degree	120	20.1	20.1	62.0
	First Degree & Professional Qualification	128	21.3	21.3	83.3
	Master Degree & Professional Qualification	100	16.7	16.7	100.0
	Total	600	100.0	100.0	

The Table 4 shows that 32 respondents representing 5.3% had SSCE/ GCE, 80 respondents representing 13.3% OND/NCE, 140 respondent representing 23.3% First Degree / HND, 120 respondent representing 20.1% Master Degree, 128 respondent representing 21.3% First Degree & Professional Qualification while 1000 respondent representing 16.7% Master Degree & Professional Qualification. Hence, the fair majority of the customers had First Degree / HND.

Table 5 Number of Losses Ever Experienced

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	None	110	18.3	18.3	18.3
	1 – 2 times	196	32.7	32.7	51.0
	3 – 4 times	238	39.7	39.7	90.7
	> 4 times	56	9.3	9.3	100.0
	Total	600	100.0	100.0	

Table 5 shows that 110 respondents representing 18.3% had no experience of losses since their policies began, 196 respondents representing 32.7% had experienced losses for between 1 to 2 times ever they started their policies, 238 respondents representing 39.7% had experienced losses for between 3-4 times while 56 respondents representing 9.3% had experienced losses for more than 4 times. Hence, the majority of sampled respondents possess substantial experience on losses, and based on this their responses could be relied upon.

Table 6 Number of Time Claim Settled

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Denied	100	16.7	16.7	16.7
	1 – 2 times	180	30.0	30.0	46.7
	3 – 4 times	246	41.0	41.0	87.7
	> 4 times	74	12.3	12.3	100.0
	Total	600	100.0	100.0	

Table 6 shows that 100 respondents representing 16.7% had claims denied based on one reason or the other, 180 respondents representing 30% had experienced claims settled for between 1 to 2 times, 246 respondents representing 41.0% had experienced claims settled for between 3 – 4 times, while 74 respondents representing 12.3% had experienced claims settled for between for more than 4 times. Hence, the majority of sampled respondents had experienced claims settled.

Analysis of Questionnaire According to Research Questions

The questions asked in this section are a summary of all questions being asked inside the questionnaires administered, bringing them under the relevant operations and procedures.

Research Question One: What is the impact of loss adjusters` competency on customers` retention in the Nigerian Insurance Industry? **(Customers part)**

Table 7 Responses Research Question One

	SA	A	U	D	SD	n
I had suffered for loss in the past	140 (46.7%)	100 (33.3%)	30 (10.0%)	18 (6.0%)	12 (4.0%)	300
When I suffered the losses, the insurer responded on time	135 (45.0%)	108 (36.0%)	34 (11.3%)	14 (4.7%)	9 (3.0%)	300
The loss adjuster gave me satisfying attentions	128 (42.7%)	98 (32.7%)	45 (15.0%)	22 (7.3%)	7 (2.3%)	300
The questions I was asked was unambiguous and straight forward	139 (46.3%)	109 (36.3%)	27 (9.0%)	18 (6.0%)	7 (2.3%)	300
The adjuster carried me along in his investigation and made every point clear to me	165 (55.0%)	112 (37.3%)	10 (3.3%)	8 (2.7%)	5 (1.7%)	300

From the table, it is shown that 140 customers representing 46.7% strongly agreed with the statement, “I had suffered for loss in the past” 107 customers representing 33.5% agreed, 30 customers representing 10% were undecided, while 18 and 12 customers represented 6% and 4% disagreed and strongly disagreed respectively. The majority of the customers had suffered losses in the past. The table also shows that 135 representing 45.0% strongly agreed 108 customers representing 36% agreed, with the statement, “When I suffered the losses the insurer responded on time” 34 customers representing 11.3% were undecided, 14 customers representing 4.7% disagreed while 9 customers representing 3% strongly disagreed. This reveals that the majority of the customers agreed that the insurer responded on time when they suffered losses.

The table further shows that 128 representing 42.7% strongly agreed, with the statement, “When The loss adjuster gave me satisfying attention” 98 customers representing 32.7% agreed, 45 customers representing 15% were undecided, 22 customers representing 7.3% disagreed while 9 customers representing 2.3% strongly disagreed. This implies that the losses the adjuster gave them satisfactory attention. The table shows that 139 customers representing 46.3% strongly agreed with the statement, “The questions I was asked was unambiguous and straight forward” 109 customers representing 36.3% agreed, 27 customers representing 9% were undecided, 18 customers representing 6% disagreed while 7 customers representing 2.3% strongly disagreed, This implies that most of the questions were simplified and straight forward. Finally, the table shows that 165 customers representing 55% strongly

agreed 112 customers representing 37.3% agreed with the statement, “The adjuster carried me along in his investigation and made every point clear to me” 10 customers representing 3.3% were undecided, 8 customers representing 2.7% disagreed while 5 customers representing 1.7% strongly disagreed. Thus, it can be validated from customers’ opinion that the adjuster carried them along in his investigation and made every point clear to them.

Research Question Two: What is the effect of loss adjusters` reports on claims managers` decisions in the Nigerian Insurance Industry? **(Adjusters part)**

Table 8 Responses Research Question Two

	SA	A	U	D	SD	n
This is not my first assignment on loss investigation in my company	137 (45.7%)	107 (35.7%)	28 (9.3%)	18 (6.0%)	10 (3.3%)	300
There is a strict rule guiding adjusters` investigation in the industry	140 (46.7%)	122 (40.7%)	29 (9.7%)	6 (2.0%)	3 (1.0%)	300
Based on experience, my pass loss reports were considered by the claim committee	160 (53.3%)	118 (39.3%)	11 (3.7%)	6 (2.0%)	5 (1.7%)	300
The insurer I work for has strict practice on adjusters` independency	157 (52.3%)	96 (32.0%)	28 (9.3%)	12 (4.0%)	7 (2.3%)	300
Where I work, there was no history of claim manipulations	159 (53.0%)	100 (33.3%)	25 (8.3%)	10 (3.3%)	6 (2.0%)	300

Table 8 that 137 adjusters representing 45.7% strongly agreed, 107 adjusters representing 35.7% agreed with the statement, “This is not my first assignment on loss investigation in my company” 28 adjusters representing 9.3% were undecided, while 18 and 10 adjusters represented 6.0% and 3.3% disagreed and strongly disagreed respectively. This reveals that most of the adjusters have been on several loss investigation assignments in their companies

The table also shows that 140 representing 46.7% strongly agreed 112 adjusters representing 40.7% agreed with the statement, “There is a strict rule guiding adjusters` investigation in the industry” 29 adjusters representing 9.7% were undecided, 6 adjusters represented 2% disagreed while 2 adjusters representing 1% strongly disagreed. Thus, it can be validated from their opinion that there are strict rules guiding adjusters` investigation in the industry.

The Table 8 further shows that 160 adjusters representing 53.5% strongly agreed, 118 adjusters representing 39.3% agreed with the statement, “Based on experience, my pass loss

reports were considered by the claim committee" 11 adjusters representing 3.7% were undecided, while 6 and 5 adjusters representing 2% and 1.7% disagreed and strongly disagreed respectively. An implication of this is that most adjusters` investigations loss reports were considered by the claim committee.

The Table 8 shows that 157 adjusters representing 52.5% strongly agreed, 96 adjusters representing 32% agreed, 28 adjusters representing 9.3% were undecided, while 12 and 7 adjusters representing 4.0% and 2.3% disagreed and strongly disagreed respectively. This implies that the insurers have strict practice on adjusters` independence in Nigeria. Finally, the table shows that 159 adjusters representing 53.5% strongly agreed, 100 adjusters representing 33.5% agreed, 25 adjusters representing 8.3% were undecided, while 10 and 6 adjusters representing 3.3 % and 2.0% disagreed and strongly disagreed respectively. This implies that most of the adjusters claimed that there was no history of claim manipulations in their workplace over a long period.

Research Question Three: What is the effect of reports time-frame and loss adjusters` work-load on customers` retention in the Nigerian Insurance Industry? **(Adjusters part)**

Table 9 Responses Research Question Three

	SA	A	U	D	SD	n
My company usually demands for a quick loss report under no time to satisfy their clients	144 (48.0%)	89 (29.7%)	34 (11.3%)	25 (8.3%)	8 (2.7%)	300
I do have many investigations at hand with a limited time	161 (53.7%)	93 (31.0%)	29 (9.7%)	10 (3.3%)	7 (2.3%)	300
I usually design a simple model to fit any investigation in order to meet up the tasks	147 (49.0%)	105 (35.0%)	27 (9.0%)	615 (5.0%)	6 (2.0%)	300
I was and I am a man of confidence, so I never disputed my results although I suffered a lot	122 (40.7%)	99 (33.0%)	49 (16.3%)	20 (6.7%)	10 (3.3%)	300
I am a profession so I should able to manage the time and workload to get the customers satisfied	139 (43.3%)	108 (36.0%)	35 (11.7%)	17 (5.7%)	4 (1.3%)	300

Table 9 shows that 144 adjusters representing 48% strongly agreed, 89 adjusters representing 29.7% agreed with the statement, "My company usually demands for a quick loss report under no time to satisfy their clients" 34 adjusters representing 11.3% were undecided while 25 and 8 adjusters representing 8.3% and 2.7% disagreed and strongly disagreed

respectively. This reveals that most of the adjusters agreed that their companies do ask for quick results. The table also shows that 161 adjusters representing 53.7% strongly agreed, 93 adjusters representing 31.0% agreed with the statement, “I do have many investigations at hand with a limited time” 29 adjusters representing 9% were undecided, while 10 and 7 adjusters representing 3.3% and 2.3% disagreed and strongly disagreed respectively. Thus, most adjusters agreed that I usually have more than a case to investigate at the same time.

However, table 9 shows that 147 adjusters representing 49% strongly agreed, 105 adjusters representing 35% agreed with the statement, “I usually design a simple model to fit any investigation in order to meet up the tasks ” 27 adjusters representing 9% were undecided while 15 and 6 adjusters representing 5% and 2% disagreed and strongly disagreed respectively, which indicate that the adjusters usually design a simple model to fit any investigation in order to meet up the tasks. The Table also shows that 122 adjusters representing 40.7% strongly agreed 99 adjusters representing 33% agreed with the statement, “I was and I am a man of confidence so I never disputed my results although I suffered a lot” 49 adjusters representing 16.3% were undecided, 20 adjusters representing 6.7% disagreed while 10 adjusters representing 3.3% strongly disagreed. Based on the responses of most adjusters, they were and they were men of trust so they never disputed the results although they suffered a lot.

Finally, the table shows that 136 adjusters representing 45.3% strongly agreed, 108 adjusters representing 36% agreed, 35 adjusters representing 11.7% were undecided, 17 adjusters representing 5.7% disagreed while 4 adjusters representing 1.3% strongly disagreed which implies that they claim to be professional so they were able to manage the time and workload to get the customers satisfied.

Research Question Four: How does loss adjusters` investigation affect customers` retention in the Nigerian Insurance Industry? **(Customers part)**

Table 10 Responses Research Question Four

	SA	A	U	D	SD	n
I agreed that there are several cases of fraud in the industry	133 (37.7%)	94 (31.3%)	65 (21.7%)	20 (6.7%)	8 (2.7%)	300
Most insured do exaggerate their losses due to lack of confidence in claim recovery	141 (47.0%)	102 (34.0%)	37 (12.3%)	15 (5.0%)	5 (1.7%)	300
I agreed that fraud and exaggerated claims would affect the potential of the industry	134 (44.7%)	118 (39.3%)	34 (11.3%)	9 (3.0%)	5 (1.7%)	300

Table 10…

which could affect my confidence as an insured						
The progress of my insurer is my progress so I believed in no fraud and exaggerated claims	165 (55.0%)	98 (32.7%)	27 (9.0%)	8 (2.7%)	2 (0.7%)	300
The regulatory authorities restored my confidence, and I believed no fraud and exaggerated claims is possible under a close-quarter practice	155 (51.7%)	88 (29.3%)	42 (14.0%)	12 (4.0%)	3 (1.0%)	300

Table 10 shows that 113 customers representing 37.7% strongly agreed with the statement, “I agreed that there are several cases of fraud in the industry” 94 customers representing 31.3% agreed, 65 customers representing 21.7% were undecided, while 20 and 8 customers represented 6.7% and 2.7% disagreed and strongly disagreed respectively. This reveals that most customers agreed that there are several cases of fraud in the industry. The table also shows that 141 representing 47% strongly agreed, 102 customers representing 34% agreed with the statement, “ 37 customers representing 12.3% were undecided, while 15 and 5 customers representing 5% and 1.7% disagreed and strongly disagreed respectively. Thus, most of the customers do exaggerate their losses due to a lack of confidence in claim recovery

The Table further shows that 134 customers representing 44.7% strongly agreed, 118 customers representing 39.3% agreed, 34 customers representing 11.3% were undecided, 9 customers representing 3% disagreed while 5 customers representing 1.7% strongly disagreed which means that remuneration is enough to compensate for a job done. The table shows that 165 customers representing 55% strongly agreed, 98 customers representing 32.7% agreed, 27 customers representing 9% were undecided, 8 customers representing 2.7% and 2 customers representing 0.7% strongly disagreed. Based on the responses of most customers, the progress of their insurer is their progress so they believed in no fraud and exaggerated claims. Finally, table 4.26 shows that 155 customers representing 51.7% strongly agreed, 88 customers representing 29.3% agreed, 42 customers representing 14% were undecided, 12 customers representing 4% disagreed while 3 customers representing 1% strongly disagreed which implies that the regulatory authorities restored most customers confidences and they believed no fraud and exaggerated claims is possible under a close-quarter practice of the authorities.

Hypotheses Testing

Hypothesis One $H0_1$:Loss adjusters` competency has no significant impact on customers` retention in the Nigerian Insurance Industry

Table 11: Loss Adjusters` Competency and Customers` Retention

	Loss adjusters` competency has no significant impact on customers` retention in the Nigerian Insurance Industry
Chi-Square	9.787[a]
Df	4
Asymp. Sig.	0.0095

Source: Authors' Computation, 2022 (SPSS-20.0)

a. 0 cells (0.0%) have expected frequencies less than 5. The minimum expected cell frequency is 6.0.

Form table above the chi-square figure of 9.787[a] and the p-value read below the table value of 0.05. (i.e, 0.0095<0.05). This confirms that Loss adjusters` competency has a significant impact on customers` retention in the Nigerian Insurance Industry

Decision: Since the p-value which the study is accept or reject the H_1 that states "Loss adjusters` competency has no significant impact on customers` retention in the Nigerian Insurance Industry is < 0.05, the H_1 is accepted, therefore, and the null hypothesis is rejected.

Hypothesis Two $H0_2$: Loss adjusters` reports has no significant effect on claims managers` decisions in the Nigerian Insurance Industry

Table 12: Loss Adjusters` Reports and Claims Managers` Decisions

	Loss adjusters` reports have no significant effect on claims managers` decisions in the Nigerian Insurance Industry
Chi-Square	9.758[a]
Df	4
Asymp. Sig.	0.0081

Source: Authors' Computation, 2022 (SPSS-20.0)

a. 0 cells (0.0%) have expected frequencies less than 5. The minimum expected cell frequency is 6.0.

Table 12, shows the chi-square figure of 9.758[a] and the p-value read below the table value of 0.05. (i.e, 0.0081<0.05). This confirms that Loss adjusters` reports have a significant effect on claims managers` decisions in the Nigerian Insurance Industry

Decision: Since the p-value which the researcher is to accept or reject the H_1 that states Loss adjusters` reports have no significant effect on claims managers` decisions in the Nigerian Insurance Industry is < 0.05, the H_1 is accepted, therefore, and the null hypothesis is rejected

Hypothesis Three $H0_3$: Reports time-frame and loss adjusters` work-load have no significant effect on customers` retention in the Nigerian Insurance Industry

Table 13: Reports time-frame and loss adjusters` work-load and customers` retention

	Reports time-frame and loss adjusters` work-load have no significant effect on customers` retention in the Nigerian Insurance Industry
Chi-Square	9.417[a]
Df	4
Asymp. Sig.	0.0089

Source: Authors' Computation, 2022 (SPSS-20.0)

a. 0 cells (0.0%) have expected frequencies less than 5. The minimum expected cell frequency is 6.0.

From table 13, the chi-square figure of 9.417[a] and the p-value reads below the table value of 0.05. (i.e, 0.0089<0.05). This confirms that Reports time-frame and loss adjusters` work-load have a significant effect on customers` retention in the Nigerian Insurance Industry

Decision: Since the p-value which the study is to accept or reject the H_1 which states that Reports time-frame and loss adjusters` work-load has no significant effect on customers` retention in the Nigerian Insurance Industry is < 0.05, the H_1 is accepted therefore and the null hypothesis is rejected.

Hypothesis Four $H0_4$: Loss adjusters` investigation has no significant effect on customers` retention in the Nigerian Insurance Industry

Table 14: Loss adjusters` investigation and customers` retention

	Loss adjusters` investigation has no significant effect on customers` retention in the Nigerian Insurance Industry
Chi-Square	9.372[a]
Df	4
Asymp. Sig.	0.0091

Source: Authors' Computation, 2022 (SPSS-20.0)

a. 0 cells (0.0%) have expected frequencies less than 5. The minimum expected cell frequency is 6.0.

From Table above, the chi-square figure of 9.372[a] and the p-value reads below the table value of 0.05. (i.e, 0.0091<0.05). This confirms that Loss adjusters` investigation has a significant effect on customers` retention in the Nigerian Insurance Industry.

Decision: Since the p-value which the study is to accept or reject the H_1 which states that Loss adjusters` investigation has no significant effect on customers` retention in the Nigerian Insurance Industry is < 0.05, the H_1 is accepted therefore and the null hypothesis is rejected.

CONCLUSIONS

From the analysis, it was obvious that most insurers leverage their claim settlements against their net premium and the condition that the coverage must be defined or covered before entitlement to claim on any policy. Considering the fact, the study concluded that the issues of not fully satisfying the customers rest upon the fact that managements do rely upon the information, or the investigation results supplied by their loss adjuster and are subject to review by the claims committee. The study also established that most insurers usually give quick attention to claim settlements thereby demanding the investigation reports within a limited time, in most cases not possible because of the work-load on the adjusters. It could also be established from the study findings that most customers who had the experience of claims denied truthfully agreed with the investigation results about the suffering the losses. And that insurer makes extra efforts to investigate the level of fraud and exaggerated claims as those claims are paid directly from their reserves which might have a great adverse effect on the firms` profits and forced such firms out of the system.

RECOMMENDATIONS

Based on the concluded facts, the study recommended:

1) That insurance company should ensure that qualified investigators (loss adjusters) who are not biased are employed to enhance effective and efficient results to engage and retain their customers in the Nigerian insurance industry
2) That insurance company should entrench strategies and training to develop their adjusters up to the required tasks and ensure that adequate tools in carrying out the investigations and the supporting teams if necessary are provided to engage and retain their customers in the Nigerian industry
3) That the insurance firms ensure that the power or tasks vested in adjusters should be independent of the management to provide unbiased results.
4) That the insurers should not forget the main reason for their existence which is bringing the insured back to his pre-loss position by paying genuine claims. Therefore, all efforts

should be made to pay genuine claims promptly as this increases the confidence of the general public in insurance and the industry as a whole.

5) The claims manager should put forward strategic plans to ensure that insurance claims complaint files are properly kept, monitored, and handled for needs that may warrant their usefulness in the future.
6) State-of-the-art training mechanisms 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.
7) That the institution regulators and other stakeholders, within the industry, should at regular intervals, intensify efforts to ascertaining the claims handling procedural methods in use by insurance companies in Nigeria

LIMITATIONS TO THE STUDY

The dearth of available data and information on Loss Adjusting delimit the extent the study can possibly go which are always shrouded away in secrecy by the Insurance Companies. Most offers, such information is treated as “classified” and not made available for research purposes. It is, however, imperative that the data used in this study is sufficient enough for generalisation.

REFERENCES

Akintayo, L. A, (2018). *Introduction to general insurance underwriting, (CSS Bookshops Limited). 2055-0286. 19*

Amoroso, C. Rebecca (2019). Driving operational excellence in loss adjustment, accessed 2, from http://www.deloitte.com

Angima, C. K. (2017). Effects of underwriting and loss adjustment on performance of property and casualty insurance companies in East Africa, no issue. *European Scientific Journal* 13(13);358

Association of Insurance and Risk Managers in Industry and Commerce (2020). *Delivery excellence in insurance claims handling: Guide to best practice.* London: AIRMIC

Brooks, P. J, Popow, D. J., and Hoopes, D. L. (2015). *Introduction to claims*, (Pennsylvania): *American Institute for Chartered Property Casualty Underwriters*

Capgemini, E. (2019). Claims transformation: Enhancing brand value by delivery on customer commitments, capturing efficiency gains, and optimizing indemnity expenditure

Cooper, P. & Emory, A (2019). *Bouncing back*, *parks & recreation*, 39(4), 28-35.

Doherty, N. Tinic, M., Seha (2016). A note on reinsurance under conditions of capital market equilibrium, *Journal of Finance* 36: 94

Iqbal, H., Rehman, M. U., & Shahzad, S. J. H. (2020). Analysis of change in profitability due to reinsurance utilization and leverage levels, *Evidence from Non-Life Insurance Sector of Pakistan. JISR-MSSE* 12(1); 16

Jacob, T. (2017). *Claims processing*, *Meeting the challenges of today and tomorrow.* Whitepaper. (UK: Microsoft Corporation)

Kim, S. (2015). Relationship between loss adjustment and firm profitability in United State of America. *Academic Research International* 1(3): 315

Kothari, C.R. (2008). *Research Methodology. Methods and Techniques* (2nd ed.). New Delhi, India: New Age International Publishers.

Putra, N. & Dharma, D. (2017). Influence growth of income, assets, ratio of claim and risk based capital on the profitability of life insurance companies in Indonesia. *International Journal of Business and Commerce* 6(9) 24

Yusuf, T.O., & Dansu, F.S. (2020) Effect of claim cost on insurers' profitability in Nigeria. *International Journal of Business and Commerce.* 3(10); 01-20