

HEALTH CLAIM PAYMENT STATUS OF NEPALESE LIFE INSURANCE COMPANIES

A Dissertation submitted to the Office of the Dean, Faculty of Management in partial
fulfilment of the requirements for the Master's Degree

By

Lisha Maharjan

Campus Roll No: 859/076

Exam Roll No : 23506/20

TU Registration No: 7-2-518-57-2015

Shanker Dev Campus

Specialization: Finance

Kathmandu Nepal

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CERTIFICATION OF AUTHORSHIP

I hereby corroborate that I have researched and submitted the final draft of dissertation entitled. **“Health Claim Payment Status of Nepalese Life Insurance Company”**. The work of this dissertation has not been submitted previously for the purpose of conferral of any degrees nor it has been proposed and presented as part of requirements for any other academic purposes. The assistance and cooperation that I have received during this research work has been acknowledged. In addition, I declare that all information sources and literature used are cited in the reference section of the dissertation.

.....

Lisha Maharjan

Date :

REPORT OF RESEARCH COMMITTEE

Ms. Lisha Maharjan has defended research proposal entitled **Health Claim Payment Status of Nepalese Life Insurance Companies** successfully. The research committee has registered the dissertation for further progress. It is recommended to carry out the work as per suggestions and guidance of supervisor Dr. Binita Manandhar and submit the thesis for evaluation and viva voce examination.

.....

Dr. Binita Manandhar
Dissertation Supervisor

Dissertation Proposal Defended Date:

Dissertation Submitted Date:

.....

Asso.Prof. Dr. Sajeeb Kumar Shrestha
Head, Research Department

Dissertation Viva Voce Date:

APPROVAL SHEET

We have examined the dissertation entitled **Health Claim Payment Status Of Nepalese Life Insurance Companies** presented by Lisha Maharjan for the degree of Master of Business Studies (MBS). We hereby certify that the dissertation is acceptable for the award of degree.

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Dr. Binita Manadhar
Dissertation Supervisor

.....

Internal Examiner

.....

Internal Expert

.....

External Expert

.....
Asso. Prof. Dr. Sajeeb Kumar Shrestha
Chairperson, Research Committee

.....

Joginder Goet
Acting Campus Chief

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I am grateful to present my dissertation titled "**HEALTH CLAIM PAYMENT STATUS OF NEPALESE LIFE INSURANCE COMPANIES** " to the esteemed head of the research department at Shanker Dev Campus. This dissertation represents partial fulfillment of the requirements for the degree of Masters in Business Studies (MBS) from the Faculty of Management, Tribhuvan University.

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ABBREVIATIONS

ANOVA	Analysis of Variance
CP	Claim paid
CV	Coefficient of Variation
H	Hypothesis
LIC	Life Insurance Company
N	Number of Observations
NICL	Nepal Insurance Company Ltd.
NLICL	National Life Insurance Company Limited
ALICI	Asian Life Insurance Company
HLI	Himalayan Life Insurance Company Limited
SPSS	Statistical Package for Social Science
SD	Standard Deviation
TU	Tribhuvan University
Sig.	Significance
RPR	Research Project Report

ABSTRACT

This thesis examines the factors that affected the claim settlement of Life Insurance of Companies in Nepal having Four samples companies Namely, they are National Life Insurance company, Himalayan Life Insurance Company Limited ,Asian Life Insurance Company and Nepal Life Insurance Company Limited out of 14 listed Life Insurance Companies in Nepal Stock Exchange. The Main Objective of the study is to find out the claim payment status of Life insurance companies and the cause of claim settlements delay. These four companies have purposively been selected to achieve the objective and answer the research questions. These four sample insurance companies have been selected on the basis of availability of data. In this study, secondary data is used. The ten fiscal year data is incorporated, from 2012/13 to 2021/22 in this study. The study is based on secondary data and primary data collection technique.

The study found that the claim amount, claim submission date, policy type affected the claim settlement process. The analysis data collection from primary data that shows claims payouts and claim processing can boost or improved for claim settlements. The companies should focus on claims payouts and improving their underwriting polices and claim processing procedures. The insights offer valuable implications for industry practitioners to sustain a competitive edge. Further, research could explore other factors influencing net profit margin in the insurance sector.

Keywords: Claim Paid , Claim submission Date, Claim Amount and Policy Type.

CHAPTER-I

INTRODUCTION

1.1 Background of the Study

For both individuals and families, life insurance is essential when it comes to risk management and financial security. It offers a vital safety net, guaranteeing loved one's financial security in the event of the policyholder's passing. The seamless and effective settlement of claims, particularly those pertaining to health and arising from disease or incapacity, is at the heart of the promise offered by life insurance. Insurance can assist split, manage, and greatly reduce them, but it cannot eliminate them. Transferring a loss from one individual or organization to another in return for money is known as insurance. The policy holder is the insured who purchases an insurance policy and transfers the risk to the insurance company, which is the insurer.

One of the industries with the most intense competition is life insurance. Due to the Covid 19 epidemic, market share has been severely disrupted and the rivalry has intensified. Settlement of claims is not an easy process. The fundamental idea is to pay for all valid claims and deny any that are incorrect. The bulk of the time, the client's ignorance of the product and its advantages is the most troublesome element. Few people actually read and comprehend the policy contract.

Yadav (2012) asserted that claim settlement is a critical component for all life insurance companies. The main source of revenue for Life Insurance Company is premium collection from the sale of insurance products. The selling of policies will be directly impacted if claims are not resolved appropriately. LIC India is well-established. Because of its superior claim settlement in the life insurance sector. He once more claimed in his research that there is a favorable correlation between sales and settlement of claims. Improved claim resolution results in increased sales and customer Arul & Kumar (2011) noted in their research that claim settlement and the quality of the services provided to clients is what matters more than other elements of life insurance.

Necessity and ramifications, regardless of whether the class is literate. If claim settlement issues were assessed, the informal way of filling out proposal forms would most likely receive a 99 percent rating. Similar to a credit card application, a life insurance proposal form is completed, signed off on, and requires only basic information like address and phone number. Not even thinking about the other disciplines. In addition to being ignorant, clients frequently refuse to share information about facts and issues. Therefore, intentionally withholds details from the proposal form, such as being ill at the time of application. Are you smoking? Family history information was incorrectly given, drinking was not disclosed on the proposal form, etc. Nepal is mostly made up of rural areas. Therefore, this rule population inevitably includes a certain percentage of the insured clients. But whether it's net business or claims, doing business in rural locations is not always easy. A claim in the context of insurance is the power that the assured exercises from an insurance contract. It is the pledge to reimburse the insurer for the premiums that were paid. Either when the insurance matures or in the event of a death, the claim may be filed. Of guaranteed, or upon willing policy surrender or obtaining information from physicians and hospitals about the care received by the deceased policy holder can be a challenge for claims officials. The insurer should request proof of legal ownership to the deceased person's estate when the life assured passes away and there is no surviving nomination or assignment under his policy. Examples of such documentation include: (a) a probate of last will and testament with will attached; (b) letters of administration; (c) a certificate of succession; and (d) a certificate issued by the administrator general. Therefore, in the event that there is no subsisting assignment or nomination, the holder may obtain the claim amount from the insurer in accordance with the policy schedule by using any of these.

The Nepali government founded "Rastrya Bima Santhan" (RBS) in 1968, and it continues to run both life and non-life insurance operations today. In 1968, the "Insurance Act" was also passed. The Ministry of Finance established the Insurance Committee that year in order to oversee and control the insurance industry. The Insurance Act of 1992 created the Insurance Board in 1992 as the organization that oversees insurance firms.

Following the reestablishment of democracy, the government liberalized the economy, leading to the creation of numerous insurance businesses around the nation. More than 35 insurance businesses were founded during this time. There are 35 insurance companies operating in the insurance industry. 14 of them offer life insurance, one offers reinsurance, and the remaining 14 have no life insurance and 7 have reinsurance & microinsurance companies 2023 Insurance Board.

Claims may include survival benefits resulting from survival up to a predetermined period throughout the term, maturity claims arising from survival until the date of maturity, or death claims arising from the guaranteed life's death during the term. Policyholders or designees have to submit an application insurance claim prior to receiving any funding. A claim for insurance is made by an insurance provider. The claim may or may not be approved by the insurance provider depending on their personal evaluation of the circumstances surrounding the allegation. One of the most crucial aspects of life insurance services is claim settlement. It is said that the actual testing of any insurance occurs throughout the claims process. When a policyholder is in need, they all anticipate a fair and easy claim settlement process. The process of settling claims typically encompasses numerous systems, procedures, and avenues. Insurance firms now focus on increasing client satisfaction, controlling claim expenses, and streamlining their claim settlement process. With a sizable client and agency base, LIC of Nepal is the top life insurance company in the country.

Currently, 14 life insurance companies operate nationwide, offering life insurance services to individuals across the nation. The insurance Board, which oversees and regulates the whole insurance sector in Nepal, is in charge of all insurance businesses operating there. Analyzing the current state of claim settlement performance for life insurers operating in Nepal is the main goal of this study.

1.2 Problem Statement

Despite the growing importance of life insurance in Nepal there is limited knowledge about the industry's health claims processes and outcomes. This research aims to assess the status of healthcare life insurance companies, with a focus on claim approval rates, average processing times and customer satisfaction. The study aims to claim payment status and identify

inefficiencies or challenges in current claims management system and propose claims processing procedures and overall service quality.

In Nepal, life insurance firms are essential to people's and families' ability to maintain financial stability. But the claim settlement procedure has been a recurring problem that has an effect on client happiness and industry trust. Sustaining these companies' good name and guaranteeing the financial security of policyholders and their beneficiaries depends on quick and transparent claim settlement.

In the context of health insurance claim settlement, extended claim settlement times pose a major difficulty. This was particularly evident for claims resolved during the COVID-19 pandemic, particularly for those that were partially settled or chose the reimbursement mechanism (Kadyan, Bhasin & Madhukar, 2022). A protracted claim settlement might involve a number of things, such as protracted claim processing timelines, postponed claim status updates, and difficulties comprehending the reimbursement procedure. Despite the many rules from Nepal, insurance companies have confronted record quantities of claims because to the rise in healthcare demands and complexities brought forth by the pandemic. This has resulted in swamped processing systems and longer turnaround times. Therefore, the inability to receive timely updates regarding the status of their claims frequently causes policyholders to feel frustrated and apprehensive. Aggravating financial strain in already difficult circumstances (Sinha, 2018). Furthermore, policyholders find it more and more difficult to navigate the reimbursement procedure, particularly when confronted with vague documentation requirements or hazy communication channels. These issues are made worse by the burden on insurance infrastructure and resources, which makes it more difficult to settle claims quickly and effectively. A major barrier to the payment of health insurance claims is the documentation complexity, which is typified by intricate claim forms, laborious procedures, and difficulties locating necessary documents. Policyholders frequently deal with a lot of paperwork and bureaucratic obstacles, putting up a lot of time and effort to compile the appropriate paperwork, such as bills and medical records. The present study aims to address the following issues

- i) What is the claim payment status of Life Insurance Company of Nepal?
- ii) Is there any relationship between claim payment and claim paid ratio?

iii) How does insurance companies settle claim payment ?

1.3 Objectives of the study

The objectives of the study are as follows.

- i) To assess of claim payment status of Life insurance company in Nepal.
- ii) To examine the relationship between claim payment and claim paid ratio of life insurance companies.
- iii) To analyze the claim payment & claim paid of life insurance companies.

1.4 Research Hypotheses

The three alternative hypotheses have been created to investigate the potential relationships between claims paid, claim amount, maturity claim amount. Each hypothesis examines whether there is a significant impact of a specific independent variable (claims details, insurance policy, customers demographics, company factor & external Factor) on a specific dependent variable (Claim payment Status). The following set of alternative hypotheses have been assumed under this research.

H1: The claim payment status of life insurance companies in Nepal is significantly influenced by policy type.

H2: There is a significant relationship between the claim payment ratio and the claim paid ratio of life insurance companies.

H3: There is a significant relationship between the claim payment amounts and the claim paid amounts of life insurance companies.

This hypothesis examines the extent to which the scale of the insurance entity influences the claim approvals.

1.5 Rationale of the Study

The aim of this research is to examine the claim payment in Life Insurance Companies in Nepal. The study emphasizes the importance of claim process management and aims to provide insights for improving the Life Insurance Companies. Effective and efficient claim settlement practices are crucial for the growth and development of the insurance industry.

Life Insurance Companies must focus on establishing a robust claim settlement practice to avoid fraud, which could erode the trust of their customers, potentially leading to a decline in Claim payment. The study has attempted to identify the significant effect of claim management on the claim settlement of insurance companies in Nepal. The results of the study can be used by insurance company executives to improve claim status by focusing on claim process management. The findings of this study have contributed to the existing body of knowledge and can be a valuable resource for future research in the field of Life Insurance Company profitability and claim management.

This study is expected to serve as a reference for new researchers who intend to carry out research on a similar field in the future. The insights and knowledge gained from this study can be used to provide a foundation for future research on the effect of Health claim status management on in the insurance industry. It is hoped that this study will aid in the improvement of claim process management practices in the insurance industry and contribute to the customer satisfaction and development of the industry.

1.6 Limitation of the Study

The study is bounded with the following limitations.

- i) This study is focused on Health claim payment status of Nepalese Life Insurance Companies.
- ii) National Life Insurance Company Limited, Asian Life Insurance Company, Himalayan Life Insurance Company Limited, Nepal Life Insurance Company Limited are taken for the study.
- iii) This Study is based on Primary and Secondary data.
- iv) This study covers ten fiscal years from 2012/2013 to 2021/2022.

CHAPTER-II

LITERATURE REVIEW

2.1 Theoretical Review

A theoretical analysis of life insurance firms' claim payment status looks at the underlying ideas and theories that guide the settlement of claims. The theoretical frameworks, models, and guiding principles included in this review are important for comprehending how insurance firms manage claim payouts, the variables affecting these procedures, and the difficulties encountered. This is a thorough theoretical overview.

2.1.1 Assessing Nepalese Life Insurance Companies' Health Claim Processing Efficiency

This article evaluates how well Nepalese life insurance firms process health claims. It includes examining customer satisfaction scores, accuracy rates, and claim processing timelines. The study's goal is to find operational inefficiencies and bottlenecks by examining claims data and customer reviews. Retaining operational efficacy and consumer trust depends on efficient processing. Gained knowledge can guide tactics for strengthening claims handling, which will ultimately improve customer satisfaction and service quality (Bhattarai et al., 2021).

In the context of health insurance claim settlement, extended claim settlement times pose a major difficulty. This was particularly evident for claims resolved during the COVID-19 pandemic, particularly for those that were partially settled or chose the reimbursement mechanism (Kadyan, Bhasin & Madhukar, 2022). A protracted claim settlement might involve a number of things, such as protracted claim processing timelines, postponed claim status updates, and difficulties comprehending the reimbursement procedure. Despite the many rules from Nepal life insurance companies, insurance companies have confronted record quantities of claims because to the rise in healthcare demands and complexities brought forth by the pandemic. This has resulted in swamped processing systems and longer turnaround times. As a result of not receiving timely information regarding the status of their claims, policyholders frequently feel frustrated and apprehensive.

2.1.2 Impact of Organizational Culture on Health Claim Payment Timeliness in Nepalese Life Insurance Companies

This research explores how organizational culture affects the timeliness of health claim payments. It examines whether companies with supportive, customer-centric cultures process claims more promptly. Organizational culture influences employee behavior and operational efficiency, impacting claim handling (Siddhanta & Roy, 2010). The study will identify cultural elements that contribute to efficient claim processing and propose ways to foster such cultures to enhance timeliness and accuracy in claim payments.

2.1.3 Challenges in Health Claim Payment Systems: A Case Study of Nepalese Life Insurance Companies

This topic investigates the specific challenges faced by Nepalese life insurance companies in managing health claim payments. It explores issues like administrative delays, claim verification hurdles, and technological constraints (Pandey & Pradhan, 2019). Through case studies, the research will highlight key problems and suggest solutions to improve the efficiency and reliability of claim processing systems, aiming to address systemic issues and enhance overall performance.

2.1.4 Arguments Regarding Exclusions, Fees, and Eligibility

Health insurance disputes involving eligibility, coverage, and exclusions are frequent and have a substantial impact on the experiences and results of policyholders. When policyholders and insurers cannot agree on whether a specific medical service or treatment is covered by the insurance plan, eligibility disputes frequently result. These disagreements could be caused by unclear policy wording, divergent interpretations, or modifications to coverage rules. Disagreements might arise, for instance, if a policyholder challenges an insurer's refusal to pay for a prescription drug or necessary medical procedure. These difficulties have been made worse by the COVID-19 pandemic, especially in terms of insurance reimbursement for COVID-19 testing and treatment. Rapid policy changes combined with extensive policy documentation have resulted in disagreements on the scope of coverage and excludes care associated with COVID-19. Such disagreements can exacerbate stress and anxiety during these uncertain times by causing delays in claims processing and increasing policyholders' financial burden. Handling a large number of

contested claims can impose a strain on insurers' resources and negatively affect their operational effectiveness, underscoring the necessity of open communication and explicit dispute resolution procedures. In the health insurance industry, charge disputes including conflicts over healthcare billing methods can pose serious difficulties, especially in light of the COVID-19 epidemic. Policyholders have the right to challenge charges, such as inflated medical bills or unanticipated out-of-pocket payments, that they believe are excessive or unreasonable. These difficulties are made worse by overcharging, a common problem in which healthcare providers overstate expenses for treatments provided to insured customers. Overcharging puts a strain on the resources of insurers and directly affects policyholders, which may result in higher premiums and a worsening of healthcare inequities. Furthermore, overcharging erodes confidence between policyholders, insurers, and healthcare providers, making it more difficult to adequately estimate the sectoral effects of healthcare spending and to allocate funds for pandemic response measures. In order to address overcharging, deliberate efforts must be made to improve the claims settlement process's transparency, honesty, and justice. This is necessary to ensure and reasonably priced healthcare, especially in times of increased health issues like the COVID-19.

2.1.5 Customer Satisfaction and Health Claim Payment: A Comparative Study of Nepalese Life Insurance Companies

This topic investigates how health claim payment processes affect customer satisfaction across different Nepalese life insurance companies. By comparing service quality and claim handling practices, the research aims to understand the relationship between payment efficiency and customer satisfaction (Dhungana & Shrestha, 2017). Surveys and interviews will reveal customer experiences and perceptions, offering recommendations for enhancing service quality and improving customer retention through effective claims management. As the cornerstones of openness, confidence, and policyholder satisfaction in the health insurance claims settlement process, customer communication and support are essential. It is imperative to maintain effective communication with policyholders during the claims process to guarantee their comprehension of their coverage benefits, claims procedures, and any necessary adjustments or denials. At every turn, insurers have an obligation to proactively furnish policyholders with lucid and all-encompassing information, so cultivating a sense of

trust and confidence and enabling them to make well-informed decisions regarding their healthcare requirements. Strong customer service systems are also essential for quickly and effectively handling the questions, worries, and complaints of policyholders. It is imperative for insurers to have easily available channels of communication, such as phone hotlines, email assistance, and online chat services, and staff these channels with individuals who are qualified to help policyholders with a range of difficulties. Furthermore, offering instructional materials such as FAQs and user manuals can aid policyholders in navigating the claims procedure and comprehending their obligation.

During extreme situations like natural disasters or public health emergencies like the COVID-19 pandemic, proactive communication and support become even more crucial. Policyholders must get updates from insurers as soon as possible regarding any short-term changes to policies, additions to coverage, or alternate service options offered while the situation is dire. Providing assistance to policyholders affected by the crisis shows compassion and support, enhancing client loyalty and confidence. In spite of the significance of customer service and assistance, insurers encounter various obstacles in providing a smooth experience.

Policyholders. Policyholder confusion can result from the intricacy and opaqueness of health insurance plans and claims procedures. misunderstanding or misinterpretation. Insurance companies need to make investments.

2.1.6 Regulatory Impact on Health Claim Payment Procedures in Nepalese Life Insurance Companies

This research explores how regulations influence health claim payment procedures within Nepalese life insurance companies. It examines the effects of regulatory frameworks on claim processing times, accuracy, and fairness (Subedi & Paudel, 2020). By analyzing current regulations and their impact, the study aims to identify areas where regulatory improvements could enhance claim payment practices and ensure a more efficient and transparent claims process. It might be difficult to navigate regulatory compliance in the settlement of health insurance claims because of the various laws from different jurisdictions. Insurance companies have to carefully handle these intricacies in the face of continuously changing laws and industry norms.

However, maintaining compliance necessitates large investments in technology, employee development, and continuous observational studies (Deloitte, 2024). Strict observance of secrecy requirements, such as those specified by legislation is necessary to address issues with data security and privacy, just like HIPAA. Insurance companies must also put strong anti-fraud measures in place. while upholding policyholder trust and meeting regulatory requirements by processing claims in a timely and accurate manner, as failing to do so may include fines, harm to one's reputation, and legal ramifications.

The COVID-19 pandemic has made regulatory compliance in the processing of health insurance claims even more crucial. Protecting patient rights, guaranteeing fair access to care, and preserving the integrity of claims processing have emerged as crucial issues when healthcare systems struggle. Patient privacy and data security are intertwined with compliance, especially in light of the growing popularity of telemedicine and remote healthcare services. Insurance companies have to balance the needs of the public health with the privacy rights of individuals while navigating changing regulatory guidelines on data sharing and permission requirements. Insurers also need to speed payment transactions, simplify the claims adjudication process, and communicate openly about coverage for COVID related services. In order to guarantee prompt access to necessary healthcare services, compliance with regulatory mandates such as the ACA's claims processing timelines and transparency requirements is vital. Attempts to improve consumer safety and lessen Abuse and fraud have also grown to be major issues. Insurance companies need to be on the lookout for new fraud schemes that take advantage of holes in the healthcare system. Adherence to rules like the Anti-Kickback Statute and False Claims Act necessitates strong measures to identify and prevent fraudulent activity.

2.1.7 Operational Difficulties

Insurance professionals have to navigate a maze of difficulties while working nonstop to settle claims accurately and morally. The process of organizing and evaluating enormous amounts of data from several sources, such as policyholders and healthcare providers, was extremely difficult. Every claim has a distinct story to tell, necessitating rigorous examination to guarantee correct results. Moreover, cultivating and maintaining connections with healthcare providers introduced an additional level of intricacy, necessitating astute

bargaining abilities and a careful balancing act between providing high-quality treatment and controlling expenses.

Amid these operational difficulties, the COVID-19 pandemic's extraordinary onset exacerbated already-existing obstacles and created new ones. The infrastructure supporting claims settlement was put under strain as telehealth services proliferated and so did the demand for documentation. In the context of COVID-19, claim verification required traversing quickly changing diagnostic criteria and treatment methods. A careful balance between meeting policyholders' healthcare requirements and guaranteeing insurers' financial stability had to be struck in the adjudication procedures.

During the epidemic, prompt claim reimbursement became crucial, as delays made people's financial situations worse and made it more difficult for healthcare professionals to offer necessary services. The need of detecting and preventing fraud increased as unscrupulous individuals looked to take advantage of holes in the healthcare system in order to benefit themselves. The administration of provider networks got more difficult due to shortages in manpower and capacity.

2.2 Empirical review

Riduwan, (2024) conducted a study on the issues of failure to pay life insurance claims. The objective of study was to analyzed impact the legal liability of insurance firms. The study used normative juridical with a statutory approach. The study found that applying the idea of absolute responsibility has an impact on insurance companies' legal liabilities; in particular, that an insurer's failure to fulfill its contractual obligations. The study concluded that management styles, business methodologies, and any differences that may impact their claim payment failure rates.

Solomon, (2024) conducted a study on effect of claim settlement on profitability of insurance companies. The objective of study was to examined the relationship between the claim settlement and profitability of insurance companies. The study used multiple regression, correlation coefficient to analyze data. The study found that the profitability and claim settlement has significant relationship. The study concluded that the more efficiently and effectively the claim settlement process operates, the greater the return on assets, return on capital invested, and earnings per share.

Khuwuka et al. (2022) conducted a study on the capacity of claims settlement of life insurance. The objective of study was to access the effect of life insurance claims settled on gross premium income. The study used multiple regression, correlation coefficient to analyze data. The study found that claim settlement has significant negative influence on gross premium income. The study concluded that more effort should be devoted for settlement of genuine life insurance claims.

Afrita, (2021) conducted a study on settlement of policy defaults between the insured and the insurer in a life insurance contract. The objective of study was to examine the connection between a customer's decision to repurchase insurance and a delayed claims settlement. The study used partial least squares to analyze data. The study found that indicated a significant positive relationship between the customer satisfaction and repurchases insurance. The study concluded that claims must be resolved fairly and swiftly. One way to achieve this would be to cut down on the amount of paperwork needed to process a claim and to communicate and report on claims as little as possible.

Dhar, (2019) conducted a study on the claim settlement mechanism. The objective of study was to examine the claim settlement procedure and its impact. . The study used average mean and percentage for analyzing data. The study found that insurance claims settlement required to facilities the handling and claim settlement procedure proactively and promptly. The study concluded that claim settlement should be more transparent and customer oriented.

Nagalakshmi, (2019) conducted a study on claim settlement ratio and process of life insurance companies. The objective of study was to examine the ratio of claim settlement of life insurance companies. The study used multiple regression, correlation coefficient to analyze data. The study found that the procedure for settlement effected the claim ratio. The study concluded that the ratio of claims to claims paid has been rising each year with advancements in the claim settlement process.

Misra, (2019) conducted a study on life Insurance Agents in Facilitating Settlement of Claims. The objective of study was to examined the life insurance agents are intended to have a significant involvement in the claim settlement process. The study used multiple regression, correlation coefficient to analyze data. The study found that running a profitable insurance agency requires professional competence. The study concluded that LIC is the firm

that consumers choose the most when buying life insurance products, even though they typically choose agents over more affordable and convenient options. Although many people are aware of and purchase term insurance, agents occasionally fail to fully explain important contract provisions, such as assignment restrictions, which causes policyholders to react differently.

Magaji, (2018) conducted a study on determination of claims settlement in insurance industry. The objective of study was to examine correlation between claim settlement and management expenses. The study used multiple regression, correlation coefficient to analyze data. The study found that management expenses and claim settlement had negative relationship. The study concluded that insurance institutions should maintain a reasonable level of administration expenses to ensure effective and sufficient handling of insurance claims.

Basaula, (2016) conducted a study on the claim settlement of life insurance in Nepal. The objective of the study was to examine the relationship between claim settlement and claim amount. The study used average mean, percentage for analyzing data. The study found indicated a significant positive relationship between the claims paid and claim amount. The study concluded that the trend of claim and claim paid seemed increasing ratio in each year.

Ashtukar, (2015) conducted a study on the analytical approach to study claim settlement of life insurance. The objective of study was to analyze the management framework provided by insurance companies regarding claim settlement. The study used percentage, mean for analyzing data. The study found that effective claim payment depends on the company policies minimum claim days and required document. The study concluded that insurance company should provide efficient service with courtesy in the matters of claim settlements and management framework (policy) are correlation between claim payment.

Singhal, (2014) conducted a study on the health insurance claims settlement. The objective of study was to identify the factors influencing in claims settlement process. The study used structural equation modeling (SEM) to analyze data. The study found that insurers lack information about the procedure. The study concluded that prolonged claim settlement times, documentation complexity, network and accuracy of claim settlement processes had a significant impact on claim settlement.

Mohania, (2013) conducted a study on the claim settlement of life insurance policies in insurance services. The objective of study was to assess the impact of claim settlement on the sales of life insurance policies. The study used partial least squares to analyze data. The study found that quality of services are related with claim settlement of life insurance. The study concluded that claim settlement ration of life insurance policies should be updated regularly and publish in various sources of information, it will be helpful for increasing the sales of Life Insurance Company.

Kumawat, (2013) conducted a study on the effects of slow claim settlement on the insurance company. The objective of study was to examine the customer's perception of existing trend of claims settlement system in the company. The study used average mean and percentage for analyzing data. The study found that prompt and satisfactory claim settlement has positive effects on sales and marketing of insurance company. The study concluded that more efficiently and effectively the claim settlement process operates, the greater the return on assets, return on capital invested, and earnings per share.

Boake, (2012) conducted a study on effected of claim settlement on net profit margin of Life Insurance Company. The objective of study was to examine the net profit margin of company. The study used multiple regression, correlation coefficient to analyze data. The study found that net profit margin affect by claim settlement of company. The study concluded that effective cost management, pricing power, and operational efficiency. Conversely, a lower net profit margin may indicate that a company is struggling to generate sufficient profits relative to its revenue.

Kung , (2010) conducted a study on the effect of settlement on life insurance market. The objective of study was to examine how the life settlement market affects the layout and composition of long-term life insurance policies that primary insurers provide. The study used multiple regression, correlation coefficient to analyze data. The study found a significant influence of settlements on life insurance market. The study concluded that life settlement market typically has a negative effect on consumer welfare by perhaps resulting in less beneficial insurance arrangements and the unraveling of dynamic contracts.

2.3 Research Gap

Despite the importance of claims payment in succeed of life insurance companies, there seems to be a gap in the literature about claim payment ratio on life insurance firms' in Nepal. Not in particular looking into how the of claim amount paid the life insurance industry's businesses in Nepal, the bulk of earlier studies have focused on the industry of general insurance (Basaula et al., 2016). Claims processing is a crucial part of the life insurance business. Although life insurance in Nepal seems to be in its infancy, claim management may play a significant role in the performance of life insurance companies. An attempt has been made to characterize and assess the claim settlement's success during the previous five years in this essay. by life insurance companies, especially in light of the total number of claims received, claims that were resolved, and the unique aspects of those claims. The claim situation is presented as it is in this article. Settlement in the life insurance industry. The deficiencies in the claim settlement procedures of Nepalese life insurance firms were noted by the literature review. According to the study's findings, regarding the overall number of claims, Nepal is presently in a developing stage of growth with regards to claim settlement. A considerable proportion of life insurers have exhibited impressive advancements in satisfying claims While some older organizations have not settled claims efficiently, several newly founded life insurance companies have expanded adequately.

A research gap is a research question or issue that hasn't been adequately or at all addressed in a particular field of study. Since research questions can only be formulated after the gap has been discovered, this stage is absolutely essential to moving forward with creating a literature review. Later on, the gap itself becomes the focus of your investigation

CHAPTER-III

RESEARCH METHODOLOGY

This chapter is devoted to the research methodology applied in the study for, the achievement for desired objectives secondary sources of data are used to conduct this study. Opinion survey technique was adopted while collecting secondary data to find out the claim amount and claim paid ration of insurance companies. The procedure directs the researcher to the study's conclusions. This chapter's primary goal is to provide an overview of the methodology used in the investigation. A methodical approach to solving a research problem is called research methodology. It describes the several processes that a researcher must take in order to explore a problem with certain goals in mind. The research design, population and sample, kind and sources of data, and techniques used for data analysis are all covered in this chapter.

3.1 Research Design

This study is based on a causal comparative research design and a descriptive research design to address the claims payment status of life insurance companies. A research design is a framework that guides the investigation and establishes the kinds, sources, and techniques for gathering data. In order to collect Secondary data and carry out appropriate information searches on performance-affecting components, this study employs a descriptive research methodology. A descriptive research strategy can study one or more variables using a wide range of research techniques. Contrary to experimental research, the researcher only observes and collects data in this type of study (McCombes, 2020).

Furthermore, the descriptive and causal comparative form of this study facilitates the examination of probable causes and effects between various dependent and independent variables. The study is related with market performance of listed insurance companies and it is based on fully secondary sources of data. Thus, analytical research design has been used.

3.2 Population and Sample

In Nepal at present there are 14 listed Life Insurance Companies are operating their business. Among the listed Life insurance Company, four are selected for research purpose. Namely,

they are Nepal Life Insurance Company Limited, National Life Insurance Company Limited, Asian Life Insurance Company, Himalayan Life Insurance Company.

The selection of these four Life Insurance Companies was done through a rigorous and thoughtful process, considering various factors such as market share, financial stability and availability of comprehensive data. These businesses offer a broad and representative sample for the study, representing a variety of segments of Nepal's life insurance market.

3.3 Sampling Method

The research attempts to concentrate on businesses with enough data points by using purposive sampling, guaranteeing a solid and trustworthy analysis. Using this method, we can deliberately choose businesses that can offer insightful information on the goals of the study, particularly the claim payments status in Nepal's life insurance market. Utilizing the In order to choose these four Life Insurance Companies, purposive sampling was used. a calculated and planned decision. As previously stated, the main standard for the availability of thorough data covering ten fiscal years, spanning from 2012/2013 and 2021/2022. This prolonged duration enables a comprehensive and examination of their financial results and claim payment trends over an extended period of time the years.

3.4 Nature and Source of Data

This study makes use of primary and secondary data. This analysis incorporates data from the ten fiscal years, ranging from 2013/2014 to 2022/2023. The research used a secondary data collection methodology. Information that has already been obtained and published by a financial institution, an organization, or a researcher is included in Primary and secondary data. Books, journals, periodicals, magazines, newspapers and website are examples of secondary data. Either published or unpublished data could be involved.

3.5 Instruments of Collection of Data

For the purpose of data analysis in this study, only secondary data from the annual reports of the ten selected life insurance companies with operations in Nepal were used. These yearly reports addressed in great detail the financial performance, claim payouts of the firms during a ten-year period, from 2012/2013 to 2021/2022.

The meticulous collecting and synthesis of secondary data from multiple reliable sources ensured the accuracy and consistency of the dataset. The process involved extracting relevant data regarding the settlement of claims and financial performance from the yearly reports of every insurance provider. After the Primary and secondary data had been gathered, the requisite statistical analysis was carried out using the data analysis software SPSS (Statistical Package for the Social Sciences). To investigate the linkages and patterns within the data, SPSS enabled a number of calculations and statistical tests.

The data was cleaned and processed to address any conflicts or missing values, ensuring the integrity of the dataset before analysis. Subsequently, the secondary data were arranged and classified based on the objectives of the research, facilitating meaningful contrasts. The data were tallied and presented in order to provide an understandable and thorough assessment of the outcomes. A variety of graphical representations, including charts and graphs, were used to visually portray the patterns and relationships between claim payouts and Claim amount.

By relying solely on secondary data from the annual reports, this research aimed to provide valuable insights claim settlement into growth of insurance companies. The thorough analysis of the secondary data enabled a comprehensive understanding of the financial dynamics within the insurance sector, contributing to the existing body of knowledge in the field.

3.6 Methods of Analysis

Microsoft Excel and SPSS, two statistical programs, are used to evaluate the data collected. Different frequency tables and percentage tables are used in descriptive analysis. Similar to this, inferential statistic tests are employed to identify and explore a variety of sample features.

3.6.1 Statistical Tools

Descriptive Statistical Tools

Descriptive statistical methods can be utilized to ascertain the trend of the financial state and claim pattern of the sample life insurance company. Analysis of the relationship between

variables also helps life insurance firms make the best decisions for accomplishing their goals. Descriptive analytical techniques such as percentage, variance, standard deviation, and mean (arithmetic) were applied in this study.

Mean

A collection of observations arithmetic mean is calculated by dividing the sum by the total number of observations. In general, if X_1, X_2, \dots, X_n are the given N observations, then their arithmetic mean, denoted by \bar{X} is given by,

$$\bar{X} = \frac{X_1 + X_2 + \dots + X_n}{N} = \frac{\sum X}{N}$$

Where, $\sum X$ = Sum of the observations, and N = Number of Years

Standard Deviation

The square root of the sum of the squares of the measured departures from the mean is the standard deviation. As a result, to calculate the standard deviation, the arithmetic average must first be determined, and then the deviation of each item from the arithmetic average must be squared. After adding up the squared deviations, the number of items is divided by the total. The series's standard deviation can be calculated by taking the resultant figure's square root (Elhance & Agarwal, 2000). The standard deviation is conventionally represented by the Greek letter sigma. If X_1, X_2, \dots, X_n is a set of N observations then, the standard deviation is given by,

$$\sigma = \sqrt{\frac{\sum (X - \bar{X})^2}{N}}$$

$\sum (X - \bar{X})^2$ = Sum of the squares of the deviations measured from mean N = Number of Observations.

Coefficient of Variation (C.V.)

For comparing the variability of two distributions, the coefficient of variation is calculated. When compared to another distribution, one is said to be more homogeneous, uniform, or

less variable, while when compared to another series, one is said to be more heterogeneous or changeable. It is calculated as follows

$$\text{C.V.} = \frac{\sigma}{\bar{X}} * 100\%$$

Inferential Statistical Tools

Inferential analysis, as opposed to data description, focusses on estimation or hypothesis testing by employing samples exclusively to make inferences about the population. This process is formally referred to as inferential statistics. This study used two examples of parametric tests: regression analysis and correlation analysis.

Coefficient of Correlation (r)

A statistical tool for examining the relationship between two variables is correlation analysis, which comprises procedures and methods for assessing the correlation and figuring out how strong it is. Using correlation analysis, we may be able to determine the direction and degree of the association between the two variables. However, the causal relationship between the variables is not taken into account. The correlation coefficient, or r, can be calculated using the following formula.

$$r = \frac{N \sum XY - \sum X \cdot \sum Y}{\sqrt{N \sum X^2 - (\sum X)^2 * \sum y^2 - (\sum y)^2}}$$

Regression Analysis

The definition of regression in the dictionary is “moving backward, going back, or returning to the average value”. One technique for analyzing the connections between variations in one series and variations in other series is regression analysis. It is established what kind and how strong the relationship is between the two variables. The process of estimating unknown values or generating predictions about one variable based on knowledge of the values of

other variables is known as regression. Regression analysis that just takes into account two variables at once is known as simple regression. The dependent variable is the unknown that needs to be predicted or approximated using a known value. When a known value is utilized for estimation or prediction, it's called is referred to as the dependent variable. The known value that is used for prediction (or estimation) is referred to as the independent (or regressed or predictor or explanatory) variable (or regressed or explained) variable (Sharma Chaudhary, 2008).

Were,

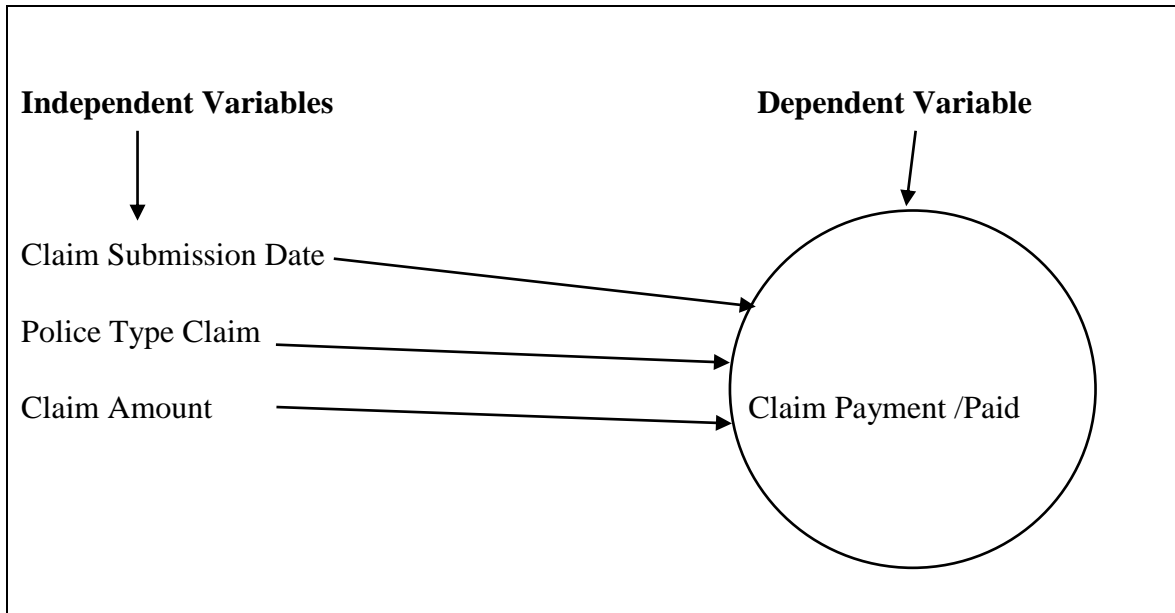
α = Constant Term

β = Coefficient of Independent Variable

CP = Claim Paid

Er = Error Terms

3.6.2 Research Framework and Definition of Variables



Source: Singhal, (2014)

Figure 1

Claim Submission Date

Claim settlement times provide a substantial difficulty. This was particularly evident for claims resolved during the COVID-19 pandemic, particularly for those that were partially settled or chose the reimbursement mode (Kadyan, Bhasin & Madhukar, 2022). Long-term claim settlement includes a number of factors, including prolonged claim processing periods, lags in receiving updates on the status of claims, and difficulties comprehending the reimbursement procedure. Given the spike in Due to the pandemic's increased complexity and demands for healthcare, insurance companies have seen historically high of claims, resulting in processing that is overloaded systems and protracted turnaround times in spite of the different recommendations.

Because of this, policyholders frequently feel frustrated and unclear about the status of their claims, which exacerbates financial stress in already difficult circumstances (Sinha, 2018). In addition, policyholders find it harder and harder to navigate the reimbursement procedure, particularly when confronted with a lack of clarity in the documentation requirements or

contact channels. These issues are made worse by the burden on insurance infrastructure and resources, which makes it more difficult to resolve claims quickly and effectively.

Policy Type Claim

Managing regulatory compliance in the settlement of health insurance claims is a complex task, made more so by the disparities in laws between different jurisdictions. Insurance companies have to carefully handle these intricacies in the face of continuously changing laws and industry norms. Nonetheless, maintaining compliance necessitates large technical expenditures, employee education, and continuous observation (Deloitte, 2024). To further address data privacy and security concerns, stringent adherence to confidentiality requirements, such as those specified in regulations like HIPAA, is necessary. In order to preserve policyholder trust and adhere to regulatory requirements, insurers must also adopt strong anti-fraud procedures and ensure prompt and correct claim processing. Failure to do so may result in financial penalties, harm to their reputation, and legal ramifications.

A major barrier to the payment of health insurance claims is the paperwork complexity, which is typified by intricate claim forms, laborious procedures, and difficulties acquiring the necessary documentation. Policyholders must spend a lot of time and energy obtaining the appropriate documentation, such as bills and medical records, and frequently deal with a lot of paperwork and bureaucratic obstacles. The process is further drawn out and causes delays when healthcare providers refuse to give these documents because of administrative hold-ups or uncooperative facilities. Complexity is further increased by challenges with policy knowledge, such as ambiguous coverage, difficult interpretations, and comprehension of policy exclusions. Disputes can arise from misinterpreting policy language, and it can be difficult to understand complicated exclusion clauses, particularly for people with little experience with insurance. Policyholders' problems are made worse by delays in communicating with insurers and the obstacles of appealing refused claims, which create uncertainty and unhappiness (Dhar & Sharma, 2019). The difficulties faced by policyholders are exacerbated by restricted access to policy information, a lack of transparency in the

settlement of claims, and inadequate assistance during the filing of claims. These factors underscore the necessity of improved transparency and support throughout the claim settlement process.

Claim Amount

An ageing population, rising healthcare expenses, and growing awareness of insurance benefits provide a significant challenge to Nepal's health insurance market. A persistent growth in claims is the sector's main impediment. In addition to the increased likelihood of false claims, controlling chronic diseases such as diabetes, hypertension, and cardiovascular problems accounts for a sizable share of these claims. Such malfeasance requires strict systems, which take a lot of time and resources to detect and prevent. Additionally, Because of the large volume of claim data, complex systems are necessary to ensure efficiency, security, and accuracy. Thus, client Policyholders may have a poorer experience with services, finding it difficult to get timely assistance and claim updates. The dynamic environment also creates difficulties for risk assessment and premium pricing, which affects the insurance products' viability and profitability (Ashturkar 2015). Stricter regulations make handling the spike in claim numbers even more difficult, and disagreements over reimbursement might erode policyholder confidence. In addition, the burden on provider networks and budgets forces insurers to come up with creative cost-cutting measures without sacrificing the caliber of healthcare services. To effectively address these complex issues, technology investments, streamlined procedures, and improved fraud detection skills are needed.

Claim Paid / Payment

A formal request for coverage or payment for a covered loss or other policy event made by a policyholder to an insurance company is known as an insurance claim. The insurance provider either approves or rejects the claim (Afolabi, 2018). The reward and recovered sum paid by the insurance provider to the policyholder for the loss or other policy event is known as a claim paid. Only the insurance company will make payments to the insured or an authorized interested party on the insured's behalf if the claim is approved.

CHAPTER –IV

RESULT AND DISCUSSION

4.1 Descriptive Analysis

The primary objective of this chapter is to assess and analyze the information acquired for the research. As detailed in chapter three, a range of statistical approaches have been used to try and accomplish the study's objectives. It offers a methodical presentation, interpretation, and analysis of secondary data in order to effectively address a multitude of problems regarding the impact of claim payment status life insurance enterprises in Nepal. The conclusions in this part have been reached by the application of appropriate statistical and financial processes. To ensure a comprehensive examination of the topic, we have employed both financial and statistical methodologies, leveraging their complimentary advantages. Combining these techniques improves our ability to spot underlying patterns and trends of claim settlement of life insurance companies.

Table 1 Status of claim paid in Rupees

Fiscal Year (AD)	NLICL	NLIC	ALICL	HLI
2012/13	897240908.00	562974120.00	82435050.00	184946588.00
2013/14	1007774685.00	779109290.00	114279243.00	516362039.00
2014/15	1147332110.00	976334217.00	119380516.00	305287852.00
2015/16	1692123713.64	1380426239.00	179989407.00	351192751.00
2016/17	2052742719.77	2975816729.00	212886864.00	518417729.00
2017/18	2968663805.74	5505477708.00	429711402.00	2435418257.00
2018/19	2893125979.00	8096198370.00	551907290.00	517644862.10
2019/20	4183950753.00	6093310846.00	1021062154.00	1361494563.65
2020/21	6276969245.00	6093310846.00	1646918776.00	2814613234.00
2021/22	8385195940.00	8910273896.00	2897183955.00	1457753269.00
Mean	3150511986	4137323226	725575465.7	1046313114
S.D	2480081542	3179314646	911961513.7	939171952.7
C.V	78.71995262	76.84472477	125.6880306	89.76012435

Source: Annual Reports

The table 1 shows claim paid (CP) amounts for different companies (NLICL,NLIC,ALIC,HLI) during specified fiscal year.

The term "Claim Paid" refers to the total sum of money that insurance companies have disbursed to satisfy claims that their policyholders have made over a specific time period. Three statistical measures the mean, the standard deviation (SD), and the coefficient of variation (CV) are provided for each company's Claim Paid in the table.

The mean claim paid out on claims during the fiscal year is shown by each company's mean claim paid. For instance, the average amount paid by NLICL to pay insurance claims is 3,15,05,11,986 which is the company's mean claim paid.

The dispersion or variability in the Claim Paid amounts for each company is measured by the standard deviation (SD). Businesses with lower SD values like HLI (SD = 93,91,71,952.7) have more reliable Claim Paid patterns, which suggests that their claim handling procedures are stable. Companies with higher SD values, such as ALICL (SD = 91,19,61,513.7), on the other hand, show more variations in their Claim Paid, indicating more erratic claim payment practices.

For every company, the relative variability of the Claim Paid amounts is expressed by the coefficient of variation, or CV. Greater relative variability, or large variations in Claim Paid amounts relative to the mean, is indicated by higher CV values. Organizations with CV ratings of 125.68, for instance, such as ALICL, indicate that their claim payment procedures are more variable than those of other organizations.

When assessing these numbers, like with any financial analysis, it is crucial to take into account extra context and industry-specific elements. The risk exposure, policy types, and claim management procedures of various insurance firms may differ, which may have an effect on the quantities of claims paid. Overall, the data suggests that the organizations have different claim payment strategies, which could be a reflection of different company priorities, plans for expansion, or requirements unique to the industry.

Table 2

*Status of Police Type Claim in Rupees**Death Claim Paid*

Fiscal Year (AD)	NLICI		NLIC		ALICI		HLI	
	Death PAID	Claim	Death PAID	Claim	Death PAID	Claim	Death PAID	Claim
2012/13	242748081		182403541		18477097		157350989	
2013/14	286084997		249505706		30436778		203857318	
2014/15	250874277		338642773		27682719		192546757	
2015/16	278213565		364856038		33455521		168779695	
2016/17	378650188		442274163		51625462		211430928	
2017/18	330501087.4		496650829		72372802		2347188980	
2018/19	355014098		496650829		73081292		332545505.1	
2019/20	627739287		482990518		104011158		280552505	
2020/21	982788994		482990518		195974917		652449856	
2021/22	787574401		731006369		205484110		500094640	
Mean	452018897.5		426797128.4		81260185.6		504679717.3	
S.D	257498071		153342621.7		68161020.41		666995138.9	
C.V	56.9662181		35.92869107		83.87997136		132.1620656	

Source: Annual Report

The Table 2 contains policy type claim (death claim payment) value of four companies, focusing on their mean, standard deviation (SD) and coefficient of variation (CV) over a certain period. NPM is a financial metric that indicates that amount of death claim payment. Analyzing the data, we observe that “ HLI “ has the highest mean 50,46,79,717.3 and “ALICI” has the lowest mean 812,60,185.6.

Higher SD values, like "HLI" imply greater variability in mean performance. The percentage-based CV values give an indication of how variable mean is in relation to the mean. Higher CV levels indicate greater relative variability in the payment data of companies like "ALICI" and "HLI." Overall, the data shows that different organizations perform at

different levels when it comes to death payment. Exhibiting payment patterns that are more constant and steadier than others.

Table 3

Maturity Claim Paid

Fiscal Year	NLICI	NLIC	ALICI	HLI
(AD)	Maturity claim paid	Maturity claim paid	Maturity claim paid	Maturity claim paid
2012/13	443527191	131785524	7647650	4025365
2013/14	511076265	177000953	9284753	5561252
2014/15	655307952	216462850	7507790	9576438
2015/16	1121944030	330125665	20753517	28336880
2016/17	1185963606	1255125330	33609430	30907489
2017/18	1342553557	1935943820	146479427	24675503
2018/19	1524855276	1935943820	204554132	74933386
2019/20	1800144081	2234710239	237620617	973624468.7
2020/21	2174022231	2234710239	332587379	1911193906
2021/22	2520071814	2329633785	689958197	290771544
Mean	1327946600	1278144223	169000289.2	335360623.2
S.D	696297922	963452078.4	216684418.8	629692019.2
C.V	52.43418085	75.37898004	128.215413	187.7656396

Source: Annual Report

The table 3 shows the policy type claim under the maturity claim paid for the different companies (NLICI,NLIC,ALICI,HLI) during a specified fiscal years.

Maturity claim payment represents the total amount of money paid out by insurance companies to cover claims filed by their policyholders during the given period. The table includes three statistical measures for each company's maturity claim paid: the mean, the standard deviation (SD), and the coefficient of variation (CV).Hence, from above table show that the claim payment has increasing each year.

Therefore, a comprehensive examination is necessary to draw meaningful conclusions and make informed assessments of each company's claim payment practices.

Table 4

Status of Other Claim Paid

Fiscal Year	NLICI	NLIC	ALICI	HLI
(AD)	Other claim paid	Other claim paid	Other claim paid	Other claim paid
2012/13	28023080	6376681	17829300	11810646
2013/14	36032784	3465135	41467225	267642268
2014/15	25664555	3302068	50422858	27969403
2015/16	44833978.3	4027467	97153351	39852391
2016/17	67774522.4	6905885	101782647	48853983
2017/18	379900705	20967050	139715942	43180768
2018/19	2574555	20967050	188305058	69844195
2019/20	103268174	24737913	568077330	74478240
2020/21	175786038	24737913	588976731	196382108
2021/22	201321511	24095237	1069822406	620020840
Mean	106517990	13958240	286355285	140003484
S.D	116576892	9791740	345364482	187320552
C.V	109.443383	70.15025	120.606987	133.797065

Source: Annual Report

The table 4 shows the policy type claim under the other claim paid for the different companies (NLICI,NLIC,ALICI,HLI) during a specified fiscal years.

Other claim payment represents the total amount of money paid out by insurance companies to cover claims filed by their policyholders during the given period. The table includes three statistical measures for each company's maturity claim paid: the mean, the standard deviation (SD), and the coefficient of variation (CV).Hence, from above table show that the claim

payment has increasing each year. Analyzing the data, we observe that ALICI has the highest mean 28,63,55,285 followed closely by HLI at 14,00,03,484.

Therefore, a comprehensive examination is necessary to draw meaningful conclusions and make informed assessments of each company's claim payment practices.

Overall, the data suggests that the organizations have different claim payment strategies, which could be a reflection of different company priorities, plans for expansion, or requirements unique to the industry.

Table 5

Descriptive Study on Claim Submission Date

Statements	N	Mean	S.D
1. I submit my claims as soon as I have the necessary documentation.	410	3.76	1.03
2. Timely submission of claims affects the payment status positively.	410	3.82	0.95
3. The submission date is clearly communicated in the claim process.	410	3.68	1.05
4. I am aware of the deadlines for submitting my claims.	410	3.85	0.88
5. Delays in submission negatively impact the speed of claim processing.	410	3.79	0.91

(Source : SPSS)

The survey data indicated that the claim submission date have low affect the claim settlement in Life insurance. Timely submission of claims affects the payment status has high mean 3.82 and a standard deviation of 0.95. As delays in submission negatively impact the claim payment has mean 3.79 and standard deviation 0.91 respondents overwhelmingly concur that filing delays have a detrimental impact on how quickly claims are processed. Although most

respondents concur that these elements have a good effect on the claim settlement process, the range of answers raises the possibility that there is room for improvement, especially in the way submission dates are communicated.

Table 6

Descriptive Study on Claim Amount

Statements	N	Mean	S.D
1. Larger claim amounts are scrutinized more closely.	410	3.74	1.00
2. The amount claimed influences the payment timeline.	410	3.70	1.05
3. I feel that my claim amount is justified based on my policy.	410	3.66	1.08
4. There are clear guidelines on how claim amounts are evaluated.	410	3.78	0.97
5. Claims with larger amounts face more obstacles in payment approval.	410	3.82	0.93

(Source: SPSS)

The survey data indicated that the Claim Amount have low affect the claim settlement in Life insurance. Larger claim amounts are scrutinized more closely has a standard deviation of 1.00 and a mean of 3.74. This indicates that the majority of respondents support the notion that higher claim amounts be examined in greater depth throughout the claim settlement procedure. Although the majority of respondents hold this opinion, there is some variation in how strongly they feel about it, as indicated by the standard deviation of 1.00. It makes sense to assume that larger claim amounts could call for more careful examinations to confirm their validity, and this extra examination might cause the settlement process to drag on longer. In conclusion, the information points to the claim amount as a major factor in the claim settlement procedure. Larger claim amounts are typically thought to be subject to extra scrutiny, which could result in lengthier payment schedules and additional challenges throughout the approval process. Although the majority of respondents believe that their

claim amounts are supported by their policies, there is a discernible difference in their opinions, suggesting that claimants' perceptions of the justification of their amounts may be influenced by their own experiences or the particulars of the policy.

Table 7

Status of Descriptive Statistics

Code	Variables	Mean	S.D
CSD	Claim Submission Date	3.72	0.815
CP	Claim Paid	907603251.19	880284497.92
PT	Policy Type	777,612,933.85	626,531,609.6
CA	Claim Amount	3.69	0.614

(Source: SPSS)

The descriptive analysis Table 5 provides information on Two different variables. The Variable CSD (Claim Submission date) exhibits mean 3.72 with a standard deviation of 0.815 , indicating that claim submission date less effect the settlement process . As Variable CA (Claim amount) exhibits mean 3.69 with a standard deviation of 0.614 which mean less effect the settlement process.

Claim Paid is the total sum of money that insurance companies have paid out to policyholders for claims that they have submitted. The average claim payment made by insurance firms is 907,603,251.19 Rupees, which is the mean claim paid. There may be some variance in the amounts paid out for claims among various insurance firms, as seen by the standard deviation of 880,284,497.92 Rupees.

4.2 Correlation Analysis

The examination of correlation The correlation coefficients between the following three variables are shown in Table 6 claim submission date , Policy Type , Claim Amount and Claim Paid / Settlement . The degree and direction of the linear link between two variables are measured by correlation coefficients. For every possible pair of variables, the correlation

coefficients are displayed in the table together with the corresponding p-values, which demonstrate how statistically significant the correlations are.

Table 8

Relation between Claim Submission date ,Policy Type , Claim Amount and Claim Paid

Variable	Claim Amount	Policy Type	Claim submission date	Claim Paid
Claim Amount	1			
Policy Type	0.122	1		
Claim Submission Date	0.45	0.65	1	
Claim Paid	0.75	0.3	0.80	1

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

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

(Source: SPSS)

The significance value is 0.001 which is less than alpha value of 0.01 ,so the correlation coefficient of 0.75, 0.3 and 0.80 . Hence, the statistically value is positive so , we can conclude that there is claim settlement / Paid depend on claim amount , claim submission date and policy type of insurer.

4.3 Regression Analysis

The findings of a multiple linear regression model, which looks at the connections between the independent and dependent variables, are shown in the tables that are provided. Although the dependent variable in this instance is not specifically stated in the table, it is probably something that the independent variables are predicting or explaining. The independent variable are Claim submission date , Policy Type and Claim Amount.

Table 9

Model Summary with Claim Paid / Settlement

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.385	.148	.115	6.84312

Predictors: (Constant), Claim Amount , Claim submission Date, Policy Type

Table 10

ANOVA with Claim Paid / Settlement

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	1217.223	3	405.741	3.286	.025
	Residual	9383.317	76	123.465		
	Total	10600.540	79			

Dependent Variable: Claim Paid/ Settlement

Predictors: (Constant), Claim Amount, Claim submission Date, Policy Type

The significance level (Sig.) of .025 and the "F" statistic of 3.286 indicates that at least one of the predictor variables has a statistically significant effect on "Claim Paid / Settlement". This suggests that the model may be able to predict how "Net Profit Margin" will change over time. Once the regression model has been taken into consideration, the "Residual" row shows the variation that cannot be explained. The dependent variable's overall variability is summed up in the "Total" row. The results indicate that although there seems to be an effect, more research is required to determine the precise roles played by the predictor factors in Claim Paid / Settlement.

Table 11

Summary of Hypotheses

Alternative Hypotheses	P-value	Remarks
H1: The claim payment status of life insurance companies in Nepal is significantly influenced by policy type.	.00	Accepted
H2: There is a significant relationship between the claim payment ratio and the claim paid ratio of life insurance companies.	.002	Accepted
H3: There is a significant relationship between the claim payment amounts and the claim paid amounts of life insurance companies.	.036	Accepted

4.4 Discussion

The findings of this study highlight several key aspects of claim payments in life insurance companies in Nepal. First, the correlation analysis revealed a robust positive relationship between the claim paid reported and the amounts claimed, with a correlation coefficient.

This study is consistent with Vinoth (2019), who also reported a positive correlation between claim Paid and Claim amount as more policies are issued, insurance companies are expected to receive more claims, which highlights how crucial efficient claims handling is to maintaining financial stability in similar industry.

The aligns with the work of Ashturkar (2015) , who also reported a significant impact between claim Paid and claim submission date in claim settlement in Life insurance company. The categories of claim submission date had a significant impact on the link between claim payments and the claim paid ratio. Different kinds of police claims were shown to have a substantial impact on overall payments, with a correlation. This suggests that insurers need to be particularly aware of the features of the claims they manage, since being aware of these subtleties can help with liability management and claim paid ratio improvements.

This study consistent with Basaula (2016), who reported that the claim settlement has been seen growing stage of development in terms of total claim, with analysis the financial data .

These findings contrast with increasing claim settlements. The differing results might be attributed to variations in the same size, specific methodologies used.

The regression analysis shed more light on the dynamics of claim payments. With an unstandardized coefficient, the claim amount was shown to be the most important predictor, indicating that increases in claim amounts result in corresponding increases in payouts. Furthermore, a positive coefficient for the quantity of policies issued indicated a correlation between policy volume and payment amounts, although a smaller influence was observed for the kind of policy claim. These results highlight the need for life insurance firms to improve their claims procedures and tactics in order to maximize profits and raise client satisfaction.

CHAPTER-V

SUMMARY AND CONCLUSION

5.1 Summary

With four sample companies, the study examines the claim payment status of Nepalese life insurance companies. Out of the 14 life insurance companies listed on the Nepal Stock Exchange, they are specifically Nepal Life Insurance Company Limited, National Life Insurance Company Limited, Asian Life Insurance Company, Himalayan Life Insurance Company. The main objective of the study is to find out the factor that affect the claim payment status of life insurance company. These four companies have purposively been selected to achieve the objective and answer the research questions. The chances of selection of Life Insurance Company are equal. These four sample insurance companies have been selected on the basis of availability of data. In this study, primary and secondary data is used. The ten fiscal year data is incorporated, from 2013/2014 to 2022/2024 in this study. The study's methodology is primary and secondary data collection. The casual comparative research design is also be used in order to determine the claim paid ratio of Life insurance company.

The analysis demonstrates that claim submission date, claim amount and policy type exert statistically significant effects on claim payment status In particular, higher claim payments are associated with claim submission date and policy type of policy holder. suggesting that higher claims settlement may occurs if the claim procedures done proactively.

The findings underscore the necessity for life insurance companies to refine their claims processes and strategies to optimize financial outcomes and enhance customer satisfaction.

5.2 Conclusion

In Conclusion, the analysis's conclusions highlight how crucial efficient claims and risk management procedures are to the life insurance sector. To strengthen their management strategies and higher the claim payment status. Businesses should work to if claims payouts and boost underwriting and claims processing protocols. The claim payment may not significant affected by claim submission date, policy type and claim amount in this model,

but it is still important for businesses to evaluate frame work for claim procedure where they can improvements in the percentage of claims settled and increase efficiency in order to guarantee the delivery of high-quality services. To better understand the connections between these predictors and claim settlement in the life insurance sector, more research is required.

The study has also revealed that life insurance companies doing business in Nepal can use the information on claims payout amounts to assess their own performance and while identifying areas where their claim and risk management procedures need to be improved.

In addition to raising claim expenses, unjustified insurance company reimbursement delays have caused hardship for the individual and damaged the industry's reputation. Policyholders are becoming increasingly concerned about this, as their lack of trust in insurance claim handling is resulting in low customer satisfaction.

5.3 Implications

The findings of the analysis provide practical implications for life insurance companies operating in Nepal. The analysis suggests that companies should focus on claims payouts and improving their underwriting policies and claims processing procedures to improve their claim payment management practices for appreciate the sensitive nature and role claim play in insurance industry. This could involve measures such as investing in technology to streamline claims processing and reducing the multiple stages in the process.

Companies should also assess their cost structures and identify areas for improvement in efficiency. Customers' needs must be met by the claim settlement process so that no one is harmed by the intricacy of the procedure when they are in need. While certain steps in the process should be avoided as they raise the cost of claim settlement, the expedited claim settlement procedure lowers the cost of processing any claim. To boost speed, policyholders should receive accurate information on a regular basis.

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APPENDICES
APPENDIX-I
QUESTIONNAIRE

Dear Sir/Madam,

I hope this message finds you well. I am currently pursuing my master's degree and conducting research on the "Health Claim Payment Status of Nepalese Life Insurance Companies." Your insights would be invaluable to my study. I kindly request your participation in a brief questionnaire related to this topic. Please rest assured that your responses will remain confidential and will be used solely for academic purposes.

Thank you very much for your time and consideration.

Best regards,

Lisha Maharjan

Section 1: Section 1: Personal Information

Please fill the box with the appropriate option number as per as applicable.

1. Age:

- Under 25
- 25-35
- 36-45
- 46-55
- Above 55

2. Gender:

- Male
- Female
- Other

3. Occupation:

- Employed
- Self-employed
- Unemployed
- Retired

4. Type of Insurance:

- Life Insurance
- Health Insurance
- Other (please specify)

Q8. Please provide the numerical score to the following questions using a 5-point scale. A scale of 1 = Strongly Disagree, 2 = Disagree, 3 = Neutral, 4 = Agree, 5 = Strongly Agree
Please cross (√) the box next to the number that best matches your opinion. Components of Participatory Culture:

5. Claim Submission Date

Claim Submission Date	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. I submit my claims as soon as I have the necessary documentation.					
2. Timely submission of claims affects the payment status positively.					
3. The submission date is clearly communicated in the claim process.					
4. I am aware of the deadlines for submitting my claims.					
5. Delays in submission negatively impact the speed of claim processing.					

Claim Amount

Claim Amount	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. Larger claim amounts are scrutinized more closely.					
2. The amount claimed influences the payment timeline.					
3. I feel that my claim amount is justified based on my policy.					
4. There are clear guidelines on how claim amounts are evaluated.					
5. Claims with larger amounts face more obstacles in payment approval.					

Descriptive Study on Claim Submission Date

Statements	N	Mean	S.D
1. I submit my claims as soon as I have the necessary documentation.	410	3.76	1.03
2. Timely submission of claims affects the payment status positively.	410	3.82	0.95
3. The submission date is clearly communicated in the claim process.	410	3.68	1.05

4. I am aware of the deadlines for submitting my claims.	410	3.85	0.88
5. Delays in submission negatively impact the speed of claim processing.	410	3.79	0.91

Descriptive Study on Claim Amount

Statements	N	Mean	S.D
1. Larger claim amounts are scrutinized more closely.	410	3.74	1.00
2. The amount claimed influences the payment timeline.	410	3.70	1.05
3. I feel that my claim amount is justified based on my policy.	410	3.66	1.08
4. There are clear guidelines on how claim amounts are evaluated.	410	3.78	0.97
5. Claims with larger amounts face more obstacles in payment approval.	410	3.82	0.93

APPENDIX-II

Fiscal Year (AD)	NLICL	NLIC	ALICL	HLI
2012/13	897240908.00	562974120.00	82435050.00	184946588.00
2013/14	1007774685.00	779109290.00	114279243.00	516362039.00
2014/15	1147332110.00	976334217.00	119380516.00	305287852.00
2015/16	1692123713.64	1380426239.00	179989407.00	351192751.00
2016/17	2052742719.77	2975816729.00	212886864.00	518417729.00
2017/18	2968663805.74	5505477708.00	429711402.00	2435418257.00
2018/19	2893125979.00	8096198370.00	551907290.00	517644862.10
2019/20	4183950753.00	6093310846.00	1021062154.00	1361494563.65
2020/21	6276969245.00	6093310846.00	1646918776.00	2814613234.00
2021/22	8385195940.00	8910273896.00	2897183955.00	1457753269.00

Death Claim Paid

Fiscal Year (AD)	NLICI	NLIC	ALICI	HLI
	Death Claim PAID	Death Claim PAID	Death Claim PAID	Death Claim PAID
2012/13	242748081	182403541	18477097	157350989
2013/14	286084997	249505706	30436778	203857318
2014/15	250874277	338642773	27682719	192546757
2015/16	278213565	364856038	33455521	168779695
2016/17	378650188	442274163	51625462	211430928
2017/18	330501087.4	496650829	72372802	2347188980
2018/19	355014098	496650829	73081292	332545505.1
2019/20	627739287	482990518	104011158	280552505
2020/21	982788994	482990518	195974917	652449856
2021/22	787574401	731006369	205484110	500094640

Maturity Claim Paid

Fiscal Year (AD)	NLICI	NLIC	ALICI	HLI
	Maturity claim paid	Maturity claim paid	Maturity claim paid	Maturity claim paid
2012/13	443527191	131785524	7647650	4025365
2013/14	511076265	177000953	9284753	5561252
2014/15	655307952	216462850	7507790	9576438
2015/16	1121944030	330125665	20753517	28336880
2016/17	1185963606	1255125330	33609430	30907489
2017/18	1342553557	1935943820	146479427	24675503
2018/19	1524855276	1935943820	204554132	74933386

2019/20	1800144081	2234710239	237620617	973624468.7
2020/21	2174022231	2234710239	332587379	1911193906
2021/22	2520071814	2329633785	689958197	290771544

Status of Other Claim Paid

	NLICI	NLIC	ALICI	HLI
Fiscal Year (AD)	Other claim paid	Other claim paid	Other claim paid	Other claim paid
2012/13	28023080	6376681	17829300	11810646
2013/14	36032784	3465135	41467225	267642268
2014/15	25664555	3302068	50422858	27969403
2015/16	44833978.3	4027467	97153351	39852391
2016/17	67774522.4	6905885	101782647	48853983
2017/18	379900705	20967050	139715942	43180768
2018/19	2574555	20967050	188305058	69844195
2019/20	103268174	24737913	568077330	74478240
2020/21	175786038	24737913	588976731	196382108
2021/22	201321511	24095237	1069822406	620020840

HEALTH CLAIM PAYMENT STATUS OF NEPALESE LIFE IN...

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ABSTRACT This thesis examines the factors that affected the claim settlement of Life Insurance of Companies in Nepal having Four samples companies Namely, they are National Life Insurance company, Himalayan Life Insurance Company Limited ,Asian Life Insurance Company and Nepal Life Insurance Company Limited out of 14 listed Life Insurance Companies in Nepal Stock Exchange.

The Main Objective of the study is to find out the claim payment status of Life insurance companies and the cause of

claim settlements delay. These four companies have purposively been selected to achieve the objective and answer the research questions. These four sample insurance companies have been selected on the basis of availability of data. In this study, secondary data is used. The ten fiscal year data is incorporated, from 2012/13 to 2021/22 in this study. The study is based on secondary data and primary data collection technique. The study found that the claim amount, claim submission date, policy type affected the claim settlement process. The analysis data collection from primary data that shows claims payouts and claim processing can boost or improved for claim settlements. The companies should focus on claims payouts and improving their underwriting polices and claim processing procedures. The insights offer valuable implications for industry practitioners to sustain a competitive edge. Further, research could explore other factors influencing net profit margin in the insurance sector. Keywords: Claim Paid , Claim submission Date, Claim Amount and Policy Type. CHAPTER-I INTRODUCTION 1.1 Background of the Study For both individuals and families, life insurance is essential when it comes to risk management and financial security. It offers a vital safety net, guaranteeing loved one's financial security in the event of the policyholder's passing. The seamless and effective settlement of claims, particularly those pertaining to health and arising from disease or incapacity, is at the heart of the promise offered by life insurance. Insurance can assist split, manage, and greatly reduce them, but it cannot eliminate them. Transferring a loss from one individual or organization to another in