**Volume 9, Issue 1, July 2026**

*Article Type: Research Article*

# Customer Satisfaction with Claim Settlement in Nepali General Insurance Companies

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**Article History**

Received on- January 13, 2026

Revised on- March 15, 2026

Accepted on- April 14, 2026

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## Abstract

**Purpose:** This study investigates claimants' perception of claim settlement practices and their perceived satisfaction regarding claim settlement in general insurance companies in Nepal.

**Design/methodology/approach:** The study employed a qualitative interpretative phenomenological design and collected data from the purposively selected claimants of six insurance companies. Thematic analysis was used to analyze the responses.

**Findings:** The four themes derived from the data – 'assorted experience', 'incongruent fiduciary duty', 'less loyalty, more attrition', and 'poor customer experience' – reveal that the satisfaction of the claimants during the claim settlement practice is not encouraging to keep the customers loyal and to make a repeat purchase of the insurance service.

**Conclusion:** The findings reveal that the satisfaction of claimants cannot be explained solely by the service they encounter during claim processing. Timely settlements, fair compensation, transparent communication, effective expectation management, and post-settlement follow-up collectively shape customers' perceptions. This highlights the need for a more holistic and customer-centered approach to claim management in the non-life insurance sector.

**Implications:** The findings have implications for both insurers and policyholders. Both these parties may work to design claim settlement mechanisms strategically to mutually imbibe the related ambiance between the insurer and the insured. Insurance companies may put in place a claim settlement process that will lift the confidence level of the claimants.

**Originality/value:** The study contributes to the limited body of qualitative research on post-purchase experiences in Nepal's non-life insurance sector and provides insights for practitioners and policymakers seeking to improve claims management practices.

**Keywords:** Claim settlement, claimants, insurance company, perceived customer satisfaction

**JEL Classification:** D12, G22, G28, L84

## Introduction

Claim settlement, in the context of insurance, is a financial compensation paid to a claimant or a policyholder as per the clauses articulated in the agreed-upon insurance policy. The concept entails a principal duty "of the insurer towards the customer" (Ghorpade, 2015), and is considered a key element for modern insurance companies to evaluate their success (Antonio & Di Trapani, 2012). The insured is entitled to his/her fortuitous loss with the hope that he/she will be indemnified by the insurer upon his/her loss. Hence, claim settlement can be understood as an underlying relationship between the insured and the insurer, and thus a vital means in boosting the image of the insurance industry.

In the past decade, particularly after the devastating earthquake of 2015 in Nepal, the insurance sector has been facing a major crunch in claim settlement (Beema Samiti, 2022; Investopaper, 2022). As stated in a recent study of life insurance companies (Tiwari et al., 2025), "most customers … are dissatisfied with several factors including marketing strategies, policy, service,

returns after maturity, and their overall trust in insurance" (p. 71). This finding speaks to the fact that there is a decrease in customer satisfaction in insurance companies, and thus, the issue is critically important for the insurance players in Nepal. In this sense, general insurance companies are also obliged to improve their competitive advantages and reconfigure their strategies, for which they need to create customer satisfaction. Hence, general insurance companies today need to realize the necessity of understanding customer satisfaction.

Insurance clients are reported to complain that the claim settlement process is slow, and the insurers are observed struggling to address the delays in settlement of insurance claims (Tiwari et al., 2025). As per the data of Nepal Insurance Authority, there have been a total of 456 complaints against insurance companies as of mid-December 2025; among these complaints, 49 have been settled, which is only 10.75 % of the total number (Insurance Khabar, 2025). This low rate highlights the challenges being faced by the insurance companies and aligns with the reports that the general insurance companies in Nepal have been experiencing a significantly high ratio of claim payables. The total claim payables reflect the outstanding liabilities of Rs. 20.84 Arab in F.Y 2080/81, and Rs. 25.02 Arab in F.Y 2081/82 (Nepal Insurance Authority, 2082 ). The statistics of earlier years reveal a similar pessimistic picture. As per the statistics of 2022, 805 complaints were registered in the past 5 years, out of which 295 issues were settled, while more than 500 cases were still to be finalized (myRepublica, 2022). This shows a noticeable difference in the number of claims payable in the general insurance companies of Nepal. This reality draws the attention of the claim managers to be ready with strategic planning to ensure effective management of claims (Yusuf et al., 2017). Acknowledging these realities, this study aims to explore consumers' perceptions of the insurance services. Particularly, the study investigates customer satisfaction with the life insurance service in Nepal.

Over the past few decades, the subject of claim settlement and customers' satisfaction towards insurance has drawn the interest of some scholars (Hoang et al., 2024; Pandey et al., 2024; Ntwali et al., 2020; Thapa, 2025; Yadav & Mohania, 2015). Most of these studies, except by Ntwali et al.(2020) and Thapa (2025), are focused on life insurance companies. They have examined, through various methods, the nature of the claim settlement process (Yadav & Mohania, 2015), factors impacting customer satisfaction (Hoang et al., 2024; Pandey et al., 2024), and the perception of the claimants (Thapa, 2025). The study of Ntwali et al. (2020) showed a strong relationship between claim settlement and customer satisfaction, and recommended that companies should "invest more in empowering its clients, especially by leveraging the advanced technology" (2020, p.191). An earlier archival study (Yadav & Mohania, 2015) had also identified shortcomings in the claim settlement process of an insurance company, and concluded that the issue of transparency and unapproachability still existed in the claim settlement process. Together, these findings reiterate the conclusion drawn in one of the seminal books of risk management and insurance – the insurance mechanism is conventional for the tenacity of reimbursement and indemnification of policyholders (Dorfman, 2004), and emphasize efficient, transparent, and technology-enabled claim settlement practices.

Studies on effective claim settlement have highlighted the importance of various factors. As stated in the study by Tajudeen and Adebowale (2013), the head of the department should be part of the top management team, staff in the claims department must be provided training, and insurance companies must internalize an organizational philosophy in the claims-handling process. Other suggestions are also offered: insurance claim departments must improve their technology to include a feedback mechanism, filing of claim process through internet and social media, and

adoption of a statistical database in tracking claim performance and claim settlement. Claim managers are also expected to possess certain qualities like understanding the customers, developing a mutually beneficial relationship with service providers, choosing the right claim models for the business, and taking greater control of the claims process and claim management (Butler & Francis, 2010; Ghimire et al., 2024). It is inferred that an insurance company can promote a healthy relationship with its clients by having proper control over the claim management process, developing a mutual relationship with other service providers, and ensuring they understand the needs of the clients. Another study by Ntwali et al. (2020) stated that claims cost control should be considered seriously as it sets a precedent on the amount of contribution that a client will be charged for renewal of policy.

Studies carried out to assess customer satisfaction have contributed to our understanding of various antecedents. Nebo and Okolo (2016), for instance, identified diverse factors liable for the satisfaction of customers, namely prompt claim settlement, prompt attendance to customer complaints, fair premiums, thorough explanation of policies, timely communication of policy renewal notices, quality insurance products, explanation of product benefits, and understandable policy documents. An earlier study by Antonio and Di Trapani (2012) had concluded that customer satisfaction is a central determinant of client retention. Any company failing to settle claims was concluded to decrease customer satisfaction of the policyholder, and thereby impact the firm's goodwill and discourage the clients from repurchasing any policy (Basaula, 2017).

The empirical literature referred to in the above paragraphs is life insurance company-focused and quantitative in design; qualitative studies examining the experience of the insured during claim settlement hardly exist. This gap necessiates further studies on this issue through a qualitative method. To address this lacuna, the study aims to answer two interrelated questions: one, how do the claimants perceive the practice of claim settlement in general insurance companies? And two, how is the perceived satisfaction of the claimants regarding claim settlement in general insurance companies?

## Research Methods

The study employed Interpretative Phenomenological Analysis (IPA) as the research design, as it is particularly well suited to the study's aim of exploring a specific phenomenon, i.e., experiences of delayed or unsettled motor and property insurance claims (Smith, 2017). This design allowed us to interpret the claimants' experiences related to insurance claim processes.

From the record of six general insurance companies in Nepal – Rastriya Beema Company Ltd., Neco Insurance Ltd., Sagarmatha Insurance Ltd. (now Sagarmatha Lumbini Insurance Co. Ltd.), Siddhartha Insurance Ltd. (now Siddhartha Premier Insurance Ltd.), NLG Insurance Co. Ltd., and Shikhar Insurance Co. Ltd. – the claimants having their claim settlement cases pending for one month to one and a half years were purposively selected. This approach is grounded on the acceptability of this sampling method in IPA to identify the information-rich participants to get the detailed insight. The following is the profile of the respondents:

**Table 1**

The Respondents' Profile

| Respondent | Claimed portfolio | Settlement due time |
|---|---|---|
| One | Motor Insurance (Third Party Liability Insurance) | 6 months |
| Two | Motor Insurance (Comprehensive Insurance) | 3-4 months |
| Three | Property Insurance (Building) | 10 months |
| Four | Motor Insurance (Comprehensive Insurance) | 1 month |
| Five | Property Insurance (Building) | 5-6 Months |
| Six | Property Insurance (Building) | 1-1.5 Years |

Data were collected from the claimants, after getting their consent, through semi-structured interviews, so as to understand their rich experience of the phenomenon. Interviews continued till data sufficiency was evident; that is, the sufficiency was observed after the fourth participant; following this, two more interviews were conducted to ensure data saturation (Guest et al., 2006). Data were analyzed using Braun and Clarke's six-step process of thematic analysis, which includes "systematically identifying, organising, and offering insight into patterns of meaning (themes) across a dataset" (2006, p.2). After the interviews, all authors read the transcribed version of the first interview independently and coded the data inductively. When inter-coder reliability was found to be higher than 80%, further coding work was entrusted to the first and second authors. All the codes from the excerpts were discussed among the researchers, and thematization was done to answer the research questions.

## Findings

The analysis of the claimants' responses through thematic analysis revealed four themes, namely 'assorted experience', 'incongruent fiduciary duty', 'less loyalty, more attrition', and 'poor customer experience'. These themes, along with their sub-themes, are discussed below.

### *Assorted Experience*

The theme "assorted experience" signifies the non-uniform nature of the claimants' experience: some shared positive experience, whereas others shared negative experience. The customers were found to have a positive experience before filing the claim, but a negative experience during the time of claim settlement. Of the two sub-themes that constituted this theme, the sub theme "positive perception" comprises the codes such as "easy claim filing", "convenient", and "no difficulty"; whereas the sub theme "negative perception" includes the codes like "challenging", "not easy filing the claim", "delayed", "no information about claim process", and "no guidance about claim process." The two sub-themes, along with the representative quotes, are presented below:

**Positive Experience:** This sub-theme appeared in the claimants having a shorter claim settlement time and a better understanding of the claim settlement process. The more the claimants were aware of the requirements, the more convenient they felt, resulting in a smoother and faster process. We present below a representative quote:

> *… it is only easy for those who have full information regarding the claim procedures. Say, for example, if a claimant knows about the documents required for processing, it is easier for them. In my case, I came and enquired at the office, which is why I was well informed about the details*. Respondent 1

Here, the claimant being 'well-informed,' particularly "about the documents required for processing," is stated to be the reason for the ease.

Another participant's experience reveals how 'being sensible' about the existing practice made preliminary work convenient: "*It was not that difficult to file a claim. It was just about filling a form, taking photographs of the damaged portion of the building, and filling in the estimated amount of the damage. Hence, the reporting of the claim was not that tough*" (Respondent 3). Filing the claim was 'not that difficult' because the participant sensed that a sample-filled form could be found on the 'damaged portion of the building.'

For others who were more technology-friendly and had a shorter claim settlement time, claim filing was even easier. One respondent who filled out the claim form online said:

> *It was a holiday or say off-time. Even at that time, I called the insurance company, and nothing wrong as such happened; it was positive. It was convenient.*
>
> *…, I did not have a talk with claim department. Whatever was required, had a talk with the marketing department's officer. She made everything convenient for me. She made me understand about whatever I was confused about, and also guided me about how to move ahead and about the process involved.* Respondent 2

As stated in the excerpt, the steps involved in filing a claim were not complicated; they were simple and easy to follow. This excerpt, along with the others presented above, reveals that claimants perceived the filing of claims as a simple process requiring only a few steps that could be easily followed by everyone.

**Negative Experience:** For those having unfamiliarity with the claim settlement process, however, the process was 'quite challenging.' Respondent 1, who described his experience of the claim-filing process as easier, stated the difficulties faced by those who do not know the process.'

> *It is quite challenging, especially if someone does not know the process. Like for example, as soon as we face the accident, we need to coordinate with the traffic police. If we do not inform the traffic police, and is not reported, claim does not come. If we don't do accordingly, nothing is going to happen.* Respondent 1

The 'need to coordinate with the traffic police' immediately after the accident is felt, and acted accordingly, only when the claimants are sensible enough of the 'necessary requirements' in the claim filing process. An oversight of any of the steps leading to 'nothing is going to happen' reveals claimants facing a denied claim.

The majority of the claimants expressed experiencing discomfort in getting cooperation during the initial phase, *i.e.*, while getting a police accident report.

> *It was not that easy. We had a hard time and hassle during making of police report…. After that, we managed the required documents and through our engineer we figured out how much to claim and we gave it to them and after that after we filed the report. And after some days they got back to us.* Respondent 5

As stated in the above excerpt, the hard time started from the initial process itself. In the latter phase, tasks like managing 'the required documents' and deploying 'our engineer' to figure out the claim amount had to be done. It can easily be inferred that the claimant started facing unease from the beginning.

For many others, the process was not easy, even though help was received initially.

> *They did not guide as such regarding the steps involved in the claim process. They just asked in the initial phase to fill out a form and send photographs. Then they said that re-insurance people will visit the scene, and further processing will take place only after that. They did not guide about the further processes involved.* Respondent 3

This vignette presents the claimant's suffering regarding the guidance during the claim process; it is clearly said that proper guidance regarding the process involved in the claim process was not received.

***Incongruent Fiduciary Duty***

This theme, concerned with the agency relationship, reveals the insurer side providing a pleasant experience through their counselling and guidance, but offering displeasing service. The theme has two sub-themes: supportive and customer-centric guidance, and poor service delivery.

**Supportive and Customer-centric Guidance**: The sub-theme, containing the codes such as 'good communication', 'good guidance', 'convenient', and 'helpful', shows the claimants experiencing attempts from the insurer to build rapport with the claimants. Some respondents experienced the insurance company personnel assisting them in the claiming process. They perceived such a response as crucial in rapport building. One of the claimants said:

> *Yes, I had a talk with the branch manager only, and he kept me informed during the claim process and was very helpful. What I did was like I added him in cc in every email where I sent the required documents so that he is also aware of the details. He made me pre aware regarding the requirements of the related documents even before the surveyor asked me to.* Respondent 4

The above excerpt demonstrates the contentment of the claimants regarding the assistance received from the branch manager. It reflects proper guidance from the insurer, which led to the satisfaction of the insured claimant.

A similar sense of convenience was felt by another claimant.

> *No, I did not talk with the claims department. Whatever was required I talked with the marketing department's officer. She made everything convenient for me. She made me understand whatever I was confused about, and also guided me about how to move ahead and about the process involved.* Respondent 2

The above excerpt demonstrates the gratification of the claimants due to the proper guidance and supervision provided by the representative of the marketing department.

An excerpt from Respondent 3 – *yes, communication was fine* – reveals the claimant's good experience with the company's communication. Another claimant also shared a similar experience, "*..., ignoring of calls did not happen. He entertained our calls and responded well enough, even there were no negligence in required visits by the concerned authorities during the claim process. I must say communication was good"* (Respondent 6). This excerpt demonstrates that personal

attention, timely response, and proper follow-ups during claim processing led to effective communication and better satisfaction of the respondent.

Some claimants experienced care with the responsible behavior of the concerned authority from the insurance company. The small gestures, such as guiding the client about ways to take photographs, are reported to add to the contentment of the clients.

> *Yes, he guided very well. He guided me well regarding how to take pics for the claim process. He also sent me the surveyor's contact details, and he even talked to and informed the surveyor himself. And then after having talk with surveyor, I started repairing my vehicle. The surveyor instructed me to take a photograph (and video, also if possible) of each and every part taken out for repair. I followed his instructions accordingly.* Respondent 4

Thus, the above excerpts demonstrate supportive and customer-centric acts from the insurance company, particularly in the domain of guidance and counselling.

**Poor Service Delivery**: This sub-theme relates to the experience of claimants with respect to the services provided to them. The theme contains codes like "lengthy process", "communication gap", "no follow-up", "no effort in settling claim", and "no insurance literacy provided".

One claimant referred to the insufficiency of literacy programs. It was conveyed that customers are not well informed about the different cuts made by insurance companies. Because of such unawareness, the claimants end up being dissatisfied as their full risk is not fully covered by the settled amount. The claimant said:

> *No, an insurance company does not inform such things in the starting phase. In my opinion, people do insurance because of obligation from the banks, as banks makes it necessary for doing insurance of the mortgage property. I think it's all because of the pressure from the bank.* Respondent 6

This excerpt demonstrates the importance of insurance literacy for the claimants. It is stated that the more insurance literacy, the clearer the claimants, thereby lessening doubts in their minds. Proper, detailed information provided in the initial phase would result in better satisfaction.

Many of the participants shared that the company's people did not give any importance to the post-purchase behavior of the client. The excerpt from one respondent contains the code "lengthy process." Here is an excerpt: "*It was not that easy a process. They told that mine details are all in a file, and there are many cases to be dealt with, so mine will take time. …. They did receive the calls, but the talk used to be very short, like your case is in process and will take time"* Respondent 5. This excerpt demonstrates longer the settlement process, the higher the discontent. In other responses, the concerned authorities are perceived to underperform, particularly in the service delivery process, showing very little concern for the satisfaction level of the client.

> *…, no follow-up call as such. I just received a call from the company to collect the cheque when it was ready. I went to receive the cheque, and that time there was some other person to handover the cheque, not that claim officer who was my friend. We did not continue any business with that company, nor did we do any deals.* Respondent 3

The above excerpt demonstrates the lack of appropriate action from the claim officer. From the perception of the client, we can conclude that a personal touch might have enhanced the overall client experience and would have led to better relationship building for a long-term business tie-

up. It also shows that personal relationships between claimant and insurer could also be hampered because of a non-congenial act demonstrated to them.

Many claimants articulated their frustration regarding the time taken for the settlement process. The fact that appropriate action was not taken in time was worrisome:

> *It took around 1 to 1.5 years. In my opinion, claim process is almost similar for all insurance companies in Nepal. All companies must have their internal processing system, etc., but all provide timely support for sure. I did feel that, and I believe all must have felt the same way during that time. I firmly believe that companies should settle the claim in a timely manner, and it is a must for them to do so, as they expect timely payment of premiums from us, and they don't issue the policy if we fail to make the payment.* Respondent 6

The above excerpt demonstrates the insurance companies not living up to the expectations of the claimant in terms of the time taken for the claim settlement.

Some claimants believed that the claim officer did not put extra effort into the re-insurance authorities, which could have been done to favor their clients for a better outcome. All these demonstrate that the insurance company's concerned authority did not deliver the expected result.

**Less Loyalty, More Attrition**

The theme of 'less loyalty, more attrition' relates to the post-purchase experience of the claimants and sheds light on repurchase intention. Two sub-themes are nested under this theme, namely post-purchase experience and repurchase intention. The first sub-theme contains the codes: "Disheartening experience", "Half a loaf is better than no bread", "Not all-risk covered", and "No full payment".

The claimants expressed discontent regarding the amount of the claim they received. Respondent 2 informed, "*..., not even 50% was covered*." The experience of another claimant was similar. An excerpt from another respondent includes the code "not all risk covered":

> *Actually, it was a matter of a minor accident, and most of the affected parts were of plastic, and in plastic parts, I guess they provide only 25 to 50% of the cost, and because of that, I did not receive the full claimed amount. I got to know about all such details only after I claimed the claim amount after facing the accident.* Respondent 4

The claimant's statement can be interpreted as evidence of post-purchase dissatisfaction arising from unmet expectations. The respondent was unhappy with the claim settlement because the compensation received was substantially lower than expected. Specifically, the customer was unaware that plastic vehicle parts were subject to partial reimbursement (25–50% of the repair cost) and only learned about this limitation after filing a claim following an accident. This points to a possible lack of transparency or insufficient communication regarding policy exclusions and depreciation provisions during the policy purchase process. Consequently, the customer's dissatisfaction appears to stem not only from the reduced claim payment but also from the realization that important policy conditions were not fully understood beforehand.

The experience of another respondent was even worse; the insurance company was found not to have set even one-fourth of the claimed amount by the claimant.

> *The overall experience was disheartening; I can't take that as positive. ..... The small amount which I received (10-12% of the claimed amount), if it would have been paid in the 1st month of the claiming, it would have been a big help as I could have utilized that money to do the repairs of the building. The amount of money that we received from the company*

*did not even suffice to pay the interest on the borrowed money which we raised from the lenders to do the repair work of the building. It was of almost no use, thereby leading to a very bad experience with the insurance company.* Respondent 3

The above excerpt indicates that the insurance company took a very long time to settle the claims and did not cover all the risks. This clearly demonstrates that the delay in payment of the claim amount, and not meeting the expectation of the claimant in terms of the amount, led to a disheartening experience.

The second sub-theme, 'purchase intention,' also demonstrates 'less loyalty, more attrition' of the claimants. A small number, particularly those who claimed for their motor insurance, shared that they would refer the insurance company to their friends and families. The reason why he will refer is because of the friendly and helpful service from the concerned authorities of the company:

*Yes, I'm recommending this insurance company to my friends and family. Regarding the company's service, like all other insurance companies, they also do not have the culture of explaining all the minute details to the person who takes insurance service, but when the claim process is initiated, as per my experience, claim department acts very friendly and is very helpful in proceedings. I'm assured in that matter, as I've already faced the situation, and if anyone is interested to take insurance from this company, I can get them insured via my friend there, hence I would certainly refer this insurance company to them.* Respondent 4

The above excerpt demonstrates that the claimant intends to refer the particular insurance company to his friends and family, as he is satisfied with the friendliness and helpfulness of the concerned authorities during the claim process.

Many other respondents, especially those who claimed for their property insurance, said they would not refer the company to others. Although the satisfaction level of the claimant was neutral, they declared that they would not refer that particular insurance company to their friends and families with the new company will give them new hope for better service and better claim returns.

*As my friend is still working in that company, I won't stop anyone if any of my known people are about to do insurance in that company, but if they ask for my suggestion, like where to do the insurance, I won't refer this company's name to them. This is the difference that came after my claim got settled. Earlier, it used to be like giving and referring all businesses to that friend, but now it's an entirely different situation.* Respondent 3

The above excerpt demonstrates that the claimant accepted the fact that he is not going to refer that particular insurance company to his friends and family. Even the personal link with the individual from the insurance company was not found to work in referring the client.

**Poor Customer Experience**

The fourth theme relating to the customers' overall experience demonstrates a large number of claimants expressing their dissatisfaction. Very few of the claimants showed their happiness; one of them, for instance, stated that his expectation was fulfilled and was happy about the amount of claim settled, "*Yes, the company fulfilled my expectations*" (Respondent 1). This statement reveals that the insurance company delivered what they promised to the claimant. Unlike this experience, others articulated their unhappiness. The theme consists of codes such as "not satisfactory", "unfulfilled expectations", "false hope of fast claim settlement", "no empathy", and quotes like

“The dog beaten by a stick gets startled when lightning strikes”, and “Bhaagna laageko baadar ko puchar vayepani samaat” (Catch even the tail of an escaping monkey).

Dissatisfaction with the insurance company’s service is expressed referring to the activities and the response of the claim department; it was perceived that the department tried to show themselves as fully occupied and had no time to communicate with the claimant. It was felt that the customer service was not delivered.

> *No empathy as such. Almost every time claim department is fully occupied, whenever I visited them, they showed themselves busy and occupied with work, and told that I'll be informed when required (i.e., my turn will come). There are lots of people like us visiting the insurance companies for claim settlement. They don't even have time to talk to us.* Respondent 5

The above excerpt demonstrates dissatisfaction of the claimant because of the lack of empathy and personalized attention from the claim department staff. This created a feeling of neglect and frustration, as the customer believed the company did not allocate adequate time to communicate during the settlement process.

Many claimants expressed that the insurance company did not meet their expectations. Their words revealed frustration with the fact that the process went on way too long. The dissatisfaction was aggravated when the insurance company pointed to a few areas for payment cuts and informed that the final amount would be settled only after those deductions.

> *..., the company did not meet my expectations. They said that as per their system, there are a few areas where they needed to cut the payments, and then finally pay the final amount. Actually, the process went a bit longer; and in a few cases, it was because of me too, so I did not have much space to talk and complain. I also was in need of money to pay my dues, so I preferred to receive the stated amount as soon as possible without further elongating the process time.* Respondent 2

The above excerpt demonstrates that the claimant was not satisfied with the settlement amount. The claim process was not smooth and timely, and at the end, the claimant had no choice but to agree to receive the offered amount due to personal obligations. Had there not been an obligation, the claimant would not have accepted the amount.

Being dissatisfied, one of the claimants made a self-decision to switch to another insurance company, although not assured of the new one, but because of feeling sort of hopeful to get a better return than the previous company.

> *No, I won't. There is a saying, right!! “The dog beaten by a stick gets startled when lightning strikes”. It happened exactly the same. I would rather choose a new company to do insurance, although I'm not assured that the new company will not betray. In my opinion, insurance is one of the ways of deceiving. But doing insurance in a new company gives you a sort of expectation/hope of getting claims paid, and the old company which has already betrayed is fully sure that it won't pay the claimed amount for sure. I don't think I'll be working with that insurance company again in the future.* Respondent 3

All these excerpts speak to the fact that the claimants were dissatisfied with various facets of service. In desperation, some consoled themselves by accepting whatever amount was offered (Respondent 2), or by making an immediate decision to change the service provider (Respondent 3).

## Discussion

Of the four themes identified in this study, the first two themes reveal a paradoxical situation in the non-life insurance sector. These themes suggest that customer evaluations of insurance services are shaped not only by the quality of interaction during claim initiation but also by the eventual outcomes of the claim settlement process.

A major source of dissatisfaction was the perceived delay in claim settlement and the substantial gap between the amount claimed and the amount reimbursed. The dissatisfaction arising from lower-than-expected settlements therefore appears to be linked not only to financial outcomes but also to inadequate expectation management throughout the process. Another important finding, the absence of meaningful post-settlement engagement, reflects a transactional rather than relational approach to customer management. The lack of such engagement may contribute to weakened customer relationships and reduce the likelihood of policy renewal despite satisfactory interactions during the earlier stages.

Some findings of this study are comparable to prior literature, though these studies do not represent the non-life insurance sector. Our findings related to the claimants' communication with the staff of the insurance company resemble the conclusion of Yadav and Mohania (2015), who inferred that approachability is a major problem during claim settlement. Similarly, the theme of 'poor customer experience' found in this study reiterates the findings of Basaula (2017).

The crux of the findings of this study can be interpreted through the lens of Expectation-Disconfirmation Theory (Oliver, 1977, 1980), which posits that customer satisfaction is determined by the gap between prior expectations of the customer and actual service performance. In the Nepali context, policyholders enter into insurance contracts with strong expectations of fair, timely, and efficient claim settlement, viewing it as a core fiduciary obligation of the insurer. However, the reported themes such as "assorted experience," "incongruent fiduciary duty," "less loyalty, more attrition," and "poor customer experience" replicate a consistent negative disconfirmation where actual experiences fall short of expectations. Delays in claim processing, inadequate compensation, and rising unpaid claims further expand this expectation-performance gap, thus leading to dissatisfaction. Consequently, as highlighted by the theme "less loyalty, more attrition," dissatisfied customers are less likely to maintain long-term relationships and renew their insurance policies with insurers. Thus, the study supports the idea that ineffective claim settlement practices in insurance companies in Nepal result in negative disconfirmation, which directly undermines customer satisfaction and overall trust in the insurance sector.

## Conclusion and Implications

The findings of the study reveal that claimant satisfaction is multidimensional and cannot be explained solely by service encounters during claim processing. Timely settlements, fair compensation, transparent communication, effective expectation management, and post-settlement follow-up collectively shape customers' perceptions of insurer performance. Consequently, insurance companies that focus primarily on operational guidance and relationship maintenance may struggle to retain customers. This highlights the need for a more holistic and customer-centered approach to claim management in the non-life insurance sector.

Further, the findings related to the claimants' perceptions of claim settlement practices and their satisfaction with claim settlement experiences indicate that claim settlement remains a critical

determinant of customers' overall evaluation of insurance services. The overall perception of the claimants reveals a paradox wherein the settlement of claims alone does not necessarily translate into customer loyalty.

The study further demonstrates that the claimants' trust in insurers is influenced not only by the final settlement outcome but also by the transparency, fairness, responsiveness, and empathy displayed throughout the process. Consequently, insurance companies in Nepal need to improve procedural efficiency, communication quality, transparency of policy provisions, and customer-oriented service delivery to strengthen trust, enhance satisfaction, and foster long-term customer relationships.

The study contributes to the limited body of qualitative research on post-purchase experiences in Nepal's non-life insurance sector and provides insights for practitioners and policymakers seeking to improve claims management practices. Hence, a few recommendations can be made. It can be recommended that claim settlement mechanisms should be designed strategically to mutually imbibe the related ambiance between the insurers and the policyholders. An appropriate emphasis could be given on the improvement in the indemnity process, showing financial stability, sincere interest of employees in solving concerns of the customers, and high-quality transaction of services. Insurance companies should put in place a claim settlement process that will lift the confidence level of the claimants, setting realistic expectations at policy issuance, strengthening customer insurance literacy, improving transparency in the claims process, training frontline staff ethically, and developing a customer feedback mechanism. Moreover, the government may also form and empower a public complaint commission to address issues relating to insurance claims.

## Limitations and Future Research

There are some limitations that are worth mentioning here. Firstly, as this is a qualitative study, the findings should not be utilized in the sense of statistical generalization. Secondly, the findings are susceptible to negative response and recall bias as the participants were reporting unpleasant experiences, and their accounts were retrospective. Thirdly, the study focused exclusively on claim settlement experiences and did not examine other facets of the issue. Fourthly, the perspectives of other key stakeholders, such as insurance company employees and regulators, were not incorporated.

Way forward: Further research may include a more diverse sample of stakeholders and compare experiences across different categories of insurance products to develop a more comprehensive understanding of customer satisfaction. Further research may be done based on the claimants' different experiences during the different phases of claim processing. One pertinent research question can be: why do the claimants have pleasant experiences while connecting with marketing personnel but not while contacting the claim officers during the process of claim settlement? Lastly, future work could also direct attention to asymmetry of information issues emanating from insurance claims settlement.

**Acknowledgement**

We extend our gratitude to Ms. Sabina Baniya Chhetri, Assistant Professor at the School of Management, Kathmandu University, for her valuable feedback while conducting this research.

## Conflict of Interest

We declare no potential conflict of interest with respect to research, submission and/or authorship of this article.


## Funding

The author(s) received no financial support for the research, publication and/or authorship of this article.


## Ethical Statement

Formal ethical approval was not required for this study, as it involved a non-clinical survey of participants' perceptions and behaviors and did not include medical procedures, experimental manipulation, animal subjects, or sensitive personal data. The study was conducted in accordance with accepted ethical standards, with voluntary participation and due protection of respondents' anonymity and confidentiality.

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**Note:** The author(s) acknowledge the use of AI-assisted tools solely for refinement of the manuscript. The authors remain fully responsible for the accuracy, validity, and integrity of the manuscript and its conclusions.