Dubai Health Insurance Complaints Management

Policy Directive

Dubai Health Insurance Corporation (DHIC)

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ACKNOWLEDGMENT

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The Authority further recognizes the commitment and diligence of all contributors in reviewing existing practices, benchmarking against international standards, and shaping provisions that strengthen beneficiary protection, enhance compliance, and promote service excellence across the health insurance sector in the Emirate of Dubai.

Dubai Health Insurance Corporation

Dubai Health Authority

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1. Legal Authority

This Regulation is issued pursuant to Dubai Health Insurance Law No. (11) of 2013, Administrative Resolution No. (78) of 2022 (Implementing Bylaw), Board Resolution No. 9 of 2011, Administrative Resolution No. (78) of 2022, Executive Council Resolution No. 16 of 2013 – Health Insurance for Dubai Government Employees and Executive Council Resolution No. (7) of 2016 on Health Insurance Fines and Fees. It is further supported by the Dubai Health Insurance Corporation's (DHIC) mandate to issue directives, circulars, manuals, and regulatory guidelines for ensuring compliance, transparency, and market integrity across all parties governed by the health insurance framework in the Emirate of Dubai.

2. Purpose

This section establishes the minimum regulatory requirements for the receipt, investigation, handling, resolution, and oversight of complaints arising within the health insurance ecosystem in the Emirate of Dubai. It aims to standardize complaints management practices across all regulated entities to ensure fairness, transparency, timely redressal, and continuous improvement in service delivery. The framework supports the Dubai Health Insurance Corporation (DHIC) in exercising its jurisdictional authority in line with DHA's strategic mandate to protect the rights of insured beneficiaries and uphold regulatory compliance by all market participants.

3. Scope of Application

This regulation applies to all entities regulated under the Dubai Health Insurance Law, including but not limited to:

- Health Insurance Companies (Insurers)
- Claim Management Companies (TPAs)
- Health Service Providers
- Insurance Brokers and Intermediaries
- Any entity involved in the design, issuance, administration, or delivery of health insurance services within the Emirate of Dubai

4. Regulatory Requirements

4.1 General Requirements

4.1.1 Jurisdiction to Review Complaints

The Dubai Health Insurance Corporation (DHIC) shall have jurisdiction to receive, investigate, and take appropriate action on complaints filed in relation to Health Services covered under the Health Insurance system or any authorized Health Insurance Policy in the Emirate of Dubai.

4.1.2 Complaint Submission Requirements

To be considered valid, any complaint submitted to the DHIC must meet the following criteria:

a) Be submitted directly by the complainant (i.e., the member or the concerned entity). If submitted by a third party, it must be accompanied by a valid power of attorney or a signed release of information letter to ensure confidentiality and legal standing of the complaint.

b) Clearly describe the subject matter and include a concise summary of the complainant's request(s).

c) Be accompanied by all supporting documents and evidence related to the complaint.

d) Comply with any additional submission requirements prescribed by the DHIC.

e) All regulated entities are required to submit their complaints to the Dubai Health Insurance Corporation (DHIC) through the Unified Complaint Management System (submit complaint) - **https://services.dha.gov.ae/mga/sps/auth**.

4.2 Complaint Escalation Protocol and Beneficiary Rights

a) A clearly documented policy and procedure must be established for the escalation of complaints, both internally within the organization and externally to the Dubai Health Insurance Corporation (DHIC)

b) Complainants must be informed of their rights, including the right to escalate unresolved complaints to DHIC.

4.3 Inadmissibility of Complaints

A complaint shall not be admissible in the following circumstances:

a) If the issue raised has already been resolved, adjudicated or resolved.

b) If the subject matter is currently under review by a judicial authority or a final judgment has been issued.

c) If more than one (1) calendar year has lapsed since the date the underlying dispute first arose.

d) If the complainant lacks legal standing or demonstrable interest in the complaint.

4.4 DHIC Responsibilities Upon Escalation of Complaints

a) Receive and register the complaint in the unified complaints system.

b) Serve the complaint and supporting documents to the respondent and require a formal response.

c) Conduct verification, review records, and consult relevant databases and subject matter experts as needed.

d) Conduct audits, inspections, or interviews to determine validity.

e) Issue a written decision and notify all parties.

Any other action as guided by DHIC management and needs.

4.5 Obligations of Stakeholders

a) Health Insurance Companies and Claims Management Companies (TPAs)

- Must establish a formal internal complaints mechanism.
- Must respond to DHIC within specified timelines.
- Must implement corrective measures if DHIC upholds the complaint.
- Must not deny legitimate complaints or delay resolution intentionally.

b) Health Service Providers

- Must cooperate fully with DHIC investigations.
- Must provide records and documentation within 3 working days of request.
- Must refrain from reactive actions against complainants, including but not limited to denial of services, alteration of medical records, patient intimidation, or termination of treatment relationships. Any form of reprisal shall be treated as a serious regulatory violation.

c) Intermediaries and Brokers

- Must disclose the complaint handling process to clients.
- Must escalate unresolved complaints to the respective insurance companies and, if needed, to DHIC.

4.6 Complaint Handling Standards for all permitted entities

a) Accessible Complaints Channels for Beneficiaries

- All Health Insurance Companies, Claim Management Companies (TPAs), and relevant regulated entities must ensure that complaints can be submitted through a minimum of five channels, including telephone, SMS, email, in-person visits, and the company website or online portal.
- Call centers must be equipped to provide multilingual support to ensure effective communication with all policyholders
- Complaints handling procedures must be clearly and proactively disclosed across all customer touchpoints, including policy documents, official websites, marketing materials, and physical office locations.

b) Logging beneficiary complaints

All complaints must be logged, preferably in an automated system, detailing:

- Name of complainant and patient (if applicable)
- Date of complaint
- Staff member receiving and registering the complaint
- Staff member to whom the complaint has been directed
- Identification of repeat complaints
- Policy details (Policy Number, Member Number, Company name)
- Intermediary name (if applicable)
- Category and detail of the complaint
- Source of complaint (telephone, email, personal visit, online facility, via a third party, etc.)

c) Complaint Assignment and Conflict of Interest Safeguards

- Each complaint must be assigned to a specific, identifiable staff member responsible for its resolution.
- Complaints shall not be handled by the individual or department that is the subject of the complaint, to ensure impartiality and avoid conflicts of interest

d) Categories of Complaints

- Denial of coverage
- Rejection of claim
- Accuracy of documentation provided

- Delays in process (refunds, reimbursements, approvals, issue of membership cards, additions or deletions of members)
- Administrative or operational process or procedures
- Product dissatisfaction or suitability
- Changes to policy terms (exclusions, conditions, renewal, premiums, network coverage)
- Service provided by staff or departments (efficiency, attitudinal, behavioral, knowledge)

e) Complaint Documentation Timelines

Complaints received must be documented within a maximum of seven (7) working days for standard cases and within twenty-four (24) hours in emergency cases, unless otherwise instructed by the DHA.

f) Complaint Resolution Timelines

Insurance companies, Claim Management Companies (TPAs) and other relevant regulated entities must assess and resolve complaints within seven (7) days of the date of receipt, unless an extension is formally granted by the DHA based on valid justification.

4.7 Staff Training

Entities must demonstrate that they have a program to train staff in complaints handling procedures, how to identify a complaint, and how complaints should be dealt with and recorded.
Training records must be maintained as part of the Training Log.
Reference: DHA Complaints Handling Policy, Section 8.1

5. Monitoring and Enforcement

5.1 Oversight Authority:

The Dubai Health Insurance Corporation (DHIC) reserves the right to conduct audits, inspections, investigations, and reviews to assess compliance with the provisions of this Regulation. These reviews may include, but are not limited to, examination of:

- Policy documentation and filings.
- Financial and pricing arrangements.
- Product structures and benefit schedules.

- Claims practices and reimbursement methodologies.
- Operational procedures and data management systems.

5.2 Enforcement action:

Any regulated entity or individual found in violation of this Regulation may be subject to one or more of the following administrative enforcement actions:

- Financial penalties in accordance with the severity and nature of the violation.
- Suspension or restriction of the entity's permit or license to operate (not product registration, as enforcement applies to regulatory authorization).
- Temporary or permanent revocation of the operating permit.
- Public listing or reporting of non-compliant entities, if deemed necessary for transparency.

5.3 Violations framework:

To support consistent and transparent enforcement, the table below outlines key regulatory violations under this Regulation, the responsible entity type, and indicative enforcement actions. All penalties and administrative measures shall be applied in accordance with the provisions of **Executive Council Resolution No. (7) of 2016 – Concerning the Implementation of Dubai Health Insurance Law No. (11) of 2013 and Executive Council Resolution No. (16) of 2013 Concerning Health Insurance of Government of Dubai Employees.** Failure to comply with any other data governance standards not explicitly specified in this Regulation shall constitute a violation subject to appropriate regulatory action.

Executive Council Resolution No. (7) of 2016 – Concerning the Implementation of Dubai Health Insurance Law No. (11) of 2013		
SN	**Violation**	**Penalty (AED)**
34	Failure by an Insurance Company or a Claim Management Company to comply with the rules, regulations, and procedures adopted by the DHA in considering and determining the complaints submitted to it	3,000.00
35	Failure by an Insurance Company or a Claim Management Company to record the complaints submitted to it, within	10,000.00

	seven (7) working days from the date of submission in normal cases, or within twenty-four (24) hours from the date of submission in Emergency Cases	
36	Failure by an Insurance Company or a Claim Management Company to determine the complaints submitted to it within thirty (30) days from the date of submission, unless the DHA extends this period for reasons given by that company	20,000.00
56	Failure by an Insurance Company, a Claim Management Company, an Insurance Broker, or a Health Service Provider, to comply with the rules, conditions, and procedures approved under the Law, or under the instructions, bylaws, and resolutions issued by the DHA	10,000.00
Executive Council Resolution No. (16) of 2013 Concerning Health Insurance of Government of Dubai Employees (Schedule 1)		
12	Failure to perform an obligation stipulated in this Resolution or the resolutions issued hereunder.	20,000.00
Executive Council Resolution No. (16) of 2013 Concerning Health Insurance of Government of Dubai Employees (Schedule 2)		
6	Failure to perform an obligation stipulated in this Resolution or the resolutions issued hereunder	25,000.00

6. Effective date and legal applicability

This Regulation shall enter effect twenty (20) calendar days from the date of its official publication by the Dubai Health Insurance Corporation (DHIC). All regulated entities shall ensure full compliance with the provisions herein within this period. Non-compliance beyond the effective date shall constitute a regulatory violation subject to enforcement under **Executive Council Resolution No. (7) of 2016 – Concerning the Implementation of Dubai Health Insurance Law No. (11) of 2013 and Executive Council Resolution No. (16) of 2013 Concerning Health Insurance of Government of Dubai Employees**.

7. References

The following legislative and regulatory instruments, policy directives, and guidance documents were consulted in the drafting of this Regulation:

1. **Dubai Health Insurance Law No. (11) of 2013** – Concerning the regulation of health insurance in the Emirate of Dubai.
2. **Executive Council Resolution No. (7) of 2016** - Concerning the Implementation of Dubai Health Insurance Law No. (11) of 2013.
3. **Administrative Resolution No. (78) of 2022** – Pertaining to enforcement and compliance under Dubai health insurance regulations.
4. **Executive Council Resolution No. (16) of 2013** – Health Insurance for Dubai Government Employees.
5. DHA regulatory documents including but not limited to:
    - PD 01-2014 - Complaints handling (rev 1)
    - PD Complaints Handling_24-11-2020
    - SN 02/2015 - Standards for health insurance intermediaries
6. Dubai Government strategic policies relating to customer service, beneficiary protection, and accessibility.
7. UAE Central Bank – Consumer Protection Standards (2021) and relevant Insurance Authority Board Decisions governing insurance company conduct, licensing, and complaints management
8. International benchmarks on health insurance complaint handling and dispute resolution, including OECD, ISO 10002:2018 (Quality Management – Customer Satisfaction – Guidelines for Complaints Handling), and World Health Organization (WHO) guidance on patient rights and grievance redressal.