The 2026 Blueprint for Modern, Compassionate, and Connected Claims

When carriers deliver on their promises through thoughtful claims, it can literally change the trajectory of someone's life.

This report compiles perspective from more than 20 life, annuity, health, final expense, and living benefits experts from every size of carrier, from Tier 1 to fraternal, on the future of claims.

benekiva.com

Meet "Judy."

Judy went to Brent Williams for advice when he was a financial advisor, long before he founded Benekiva. Brent could have sold her an expensive whole life policy or a portfolio of other products that maximized commission. Instead, he focused on what Judy actually needed: a simple term life policy paired with an accelerated death benefit.

Fast forward three years to the day, Judy was diagnosed with cancer and told that her time was limited.

Because of the policy design, Judy was able to access $600,000 of her life insurance while she was alive. She found a care facility that was not covered by insurance, treatment she never would've been able to afford otherwise. That care saved her life.

More than a decade later, Judy still talks to Brent regularly.

This is the promise of claims when they work: dignity, speed, and outcomes that matter. We work in life, annuities, and living benefits insurance because the work we do can change the trajectory of someone's life, or the life of their loved ones.

Meet "Joe."

Joe called Brent after losing his father. His father had been careful with eight separate policies across multiple carriers to ensure Joe's mother would be financially secure.

It took nine months for Joe to receive the final payout.

- Nine months to access money needed for funeral costs.
- Nine months to support his mother's care.
- Nine months of uncertainty, follow-ups, and waiting.

This is the other side of claims.

We promise protection. Then, too often, we make people wait.

This report explores that tension, between what claims can be and what they are today. It reflects conversations with claims examiners, claims leaders, executives, consultants, system integrators, and technology partners across the industry. Together, they paint a clear picture: claims are at an inflection point.

Table of Contents

A Thank You to our Thought Leaders 3

The Hidden Reality of Today's Claims Experience 4

A Better Future: Proactive, Connected Claims 6

Making Claims Better: Four Perspectives 11

- Company-Wide Takeaways 11
- Executive Focuses 18
- Operations and Technology Focuses 20
- Claim Leader Focuses 24

A Thank You to our Thought Leaders

This report was created with the perspective of dozens of claims experts representing hundreds of years of combined experience in life, annuities, and living benefits claims. We'd like to thank the executives, claims leaders, examiners, and claims thought leaders who shared their thoughts to make this report possible.

Disclaimer: Quotes and perspectives in this report represent the interviewees' individual views and do not imply endorsement or partnership with Benekiva.

The Hidden Reality of Claims Today

From the outside, claims are often seen as administrative. Necessary. Costly. Operational.

The opposite couldn't be more true.

Claims teams sit at the intersection of grief, urgency, regulation, and complexity. They manage systems built decades apart, rules that vary by state and product, and processes designed around human workarounds rather than human outcomes.

Across interviews, several themes surfaced again and again.

1 • Time is the Enemy

Claim delays rarely come from lack of care. They come from friction.

One claims examiner described her day not as "processing claims," but as preparing them so automation doesn't fail.

"I spend a good portion of my day uploading claims and putting those into the system... all day long."

That work isn't just clerical. First notice of loss (FNOL) errors can derail straight-through processing, triggering audits, reviews, and rework downstream. Every extra touch adds time and risk.

2 • Digital is Still Rare

It's astonishing how many claims still come in via fax. We talk to carriers who regularly spend tens of thousands of hours per year taking calls for their life, annuities, and living benefits claims. Even "digital" FNOLs can be time-consuming; these digital FNOLs can mean that they've simply turned forms into a static PDF without any automation for loading them in a system. Is re-keying a digital form from email really better than re-keying a paper form? Both take precious time and introduce risk for errors.

Other manual or paper processes we regularly encounter in day-to-day conversations with claims teams include the following:

- Payments are still often sent via check when the claimant expectations are increasingly near-real-time digital payout
- Interest calculated manually with a calculator or spreadsheet
- Paper correspondence or manual processes requiring teams to type every letter
- Manual case distribution
- Manual report creation for SLA or regulation tracking

A unique challenge for life insurers is the longevity of data. Mark Aul, Head of Service Operations at GBU Life shares:

"Sometimes we get digital files. Sometimes we only get image files. Typically the older the policy, the more likely it is that we have to go back to a visual review of the beneficiaries."

These files are also inherited when carriers merge. There's a quiet tax to longevity: the older the book of business, the more the claims experience depends on how readable the past still is.

3 • Complexity Hides in the Margins

From 18-beneficiary life claims to losses that trigger claims across multiple policies, even highly automated organizations struggle with the last mile.

One company we spoke to can straight-through process most claims – until they hit edge cases. Utah, for example, changes their interest rates daily and requires interest calculations based on the claimant's day of death. In order to access the latest rate update, examiners literally have to go to the Utah website to see that day's update. One volatile rule can halt automation at the finish line.

4 • Burnout Isn't Always About Compassion Fatigue

Claims teams don't burn out because they care too much. They burn out because the work is harder than it needs to be.

BreAnna McGee, a Business Analyst at Wellabe, frames her role simply:

"If I can reduce clicks for the team, or reduce phone calls for the team, then it's a win."

Click fatigue is significant. Manual reconciliation is significant. Context switching across systems is significant. Over time, it erodes morale and increases error rates. It costs companies valuable time, but even more valuable talent.

Another claims leader shared,

"I'm dealing with people that are at their lowest moment. They've lost a loved one. They're going through any stage of grief, from anger to just complete denial. So you have those challenges and then you have an antiquated process to support that. And then you're not feeling supported because we're basically yelling out 'I need help, I need resources, I need automation, I need some investment,' and it's hard to be heard, especially when we're busy making others feel heard."

The claims leader went on to share that burnout has a cyclical effect:

"Especially in a small department, even losing one person to burnout is a hard loss. It can feel like a never-ending cycle of training and onboarding as different team members get burned out and leave, leaving me to retrain new person after new person, which leads to my own burnout. And just when you get someone up to speed, understanding the complexity of claims, then they say, 'this is not for me. I can't handle hearing about another tragic death.' It weighs on you from a mental health standpoint. Add to that also helping your team carry their own mental and emotional loads as a claims examiner, the weight can feel suffocating, like the weight of the world."

A Better Future:
Proactive, Connected Claims

"Success is whenthe benefit shows up and the beneficiary didn't even know it was coming." Brent Williams, Founder & CEO of Benekiva

Insurance on the whole went through a tidal wave of change in 2021. During the Covid pandemic, insurers had offices full of paper files and processes and faced the challenge of digitizing as much as possible as fast as possible.

Simultaneously, the expectations for digital experiences rose exponentially. As Chris Stanley, VP of Underwriting and Claims at Bankers Fidelity explained:

"We're now all in the world of instant gratification: 'I submitted the claim this morning – where is it?' Claimants want less forms, faster answers, proactive updates."

Carriers must continually transform to keep pace with ever-rising expectations.

Let's put our Jettson's goggles on for a moment and imagine the most idealized version of a claim experience from the claimant's perspective.

Let's use a term life policy for our example. In the best-case scenario, the beneficiary receives payment directly to their bank account before they even had to report the death to the insurance company.

It sounds unrealistic, right?

But the technology isn't far off.

If a proactive identification of death triggered a claim to start, the claim system could pull in the death and beneficiary data from external sources, validating it with publicly accessible data. Assuming the data was reliable and comprehensive, and the claim was simple (say, single beneficiary), it could be straight-through processed.

Carrier Data Network

Death Audit
Public Data Sources
Government Records

New Claim Initiated
- Phone
- Web
- Email
- Agent Portal
- Death Audit

Data Intake & Validation

Connected Claims Intelligence
- Data Ingestion
- Verification
- Enrichment
- Decisioning

Insights & Decisioning

Claim Decision & Action

Provides:
Proof of death
Verified source data
Beneficiary insights
Contact information
Fraud checks

Enables:
Faster payments
Automation
Agent engagement

As Rob Strange, Sr. Director, Client Success, Transformation, & ACT Strategy at Evadata, puts it:

"The claims process is backwards today. It puts the heaviest burden on the person least equipped to carry it — the beneficiary — and technology should reverse that burden."

The traditional life insurance model looks like the following:

1. The beneficiary searches for a policy relevant to a loved one.
2. The beneficiary tracks down contact information for the insurance company.
3. The call or submit a first notice of loss online.
4. In a series of back-and-forth conversations, the beneficiary gathers and provide relevant documentation.
5. The carrier validates the provided information.
6. The carrier tracks down all relevant beneficiary information.

The claim slowly progresses through a series of back-and-forths.

But imagine a world where we could flip the model on its head:

1. Carrier proactively detects death via database
2. Claim is auto-created in system
3. Beneficiary receives outreach from the carrier with instructions guiding them through the process ("We're here when you're ready")
4. The proof of death is already validated and beneficiary information is at least partially populated
5. The beneficiary can log into a portal to provide lightweight confirmation.
6. The carrier pays out the claim.

The claim can be paid faster, with fewer touchpoints, and with far less burden on the beneficiary.

What a different experience the claimant would have if the carrier was able to reach out first and say, **"We are so sorry for your loss. Here's how you can get started when you're ready."**

What a different reputation insurance would have on the whole.

But even with a clear vision of the future, one question remains: who will deliver it?

The People Problem Isn't What We Thought

The Workforce Cliff Didn't Happen — and That Tells Us Something

For years, industry headlines have warned that automation would shrink claims teams. That artificial intelligence and digital transformation would reduce headcount. That modernization meant fewer people.

At the same time:

50%

of companies plan to increase staff

43%

plan to maintain current staffing levels

72%

expect revenue growth

In other words: revenue expectations are rising, and staffing is rising with it. This is not an industry preparing to eliminate people. It's an industry trying to keep up.

The data tells a different story.

According to the Q1 2026 Insurance Labor Market Study from The Jacobson Group and Aon's Strategy and Technology Group, only 7% of companies plan to reduce staff in the next 12 months — a dramatic drop from 14% just six months earlier and among the lowest levels recorded in the study's history.

Growth Still Requires People, Even in an Automated World

One of the more telling charts in the study shows expected revenue growth consistently outpacing staffing reductions from 2009 through early 2026. While expected revenue growth sits at 72%, only 7% of companies expect staffing decreases.

That delta matters.

If automation were replacing claims professionals at scale, we would expect to see staffing plans decline as revenue increases. Instead, we see the opposite: companies are adding capacity.

Even in Life/Health, the segment most relevant to many of the interviews in this report, 60% planned to increase employees, and only 20% reported actual decreases.

The message is clear: technology is not eliminating claims roles. It is enabling growth.

As one claims examiner put it, reflecting on the future:

"There are certain products that will never be able to be automated ever. For example, I can't see AI automating accidental death."

Straight-through processing is happening. AI is assisting. But judgment, empathy, and interpretation still require people.

Automation Isn't Replacing Humans. It's Protecting Them

As Kristen Crook, Director of Customer Success at Benekiva stated:
"AI cannot replace compassion and empathy. I mean, it does a good job. Sometimes I talk to it and it makes me feel good, you know? But when you answer that phone, AI can't hear the silence. AI can't hear you crying. That's where we step in."

Claims work is cognitively and emotionally demanding. If AI replaces anything, it is not the examiner. It is the repetitive friction that drains them.

This matches what we heard across interviews:

- Examiners want fewer swivel-chair steps.
- Leaders want fewer workarounds.
- Engineers want to close the 80/20 gap.
- Executives want growth without burnout.

Technology, when done well, gives time back.

- It reduces the 9-screen shuffle.
- It eliminates manual interest calculations.
- It surfaces documents instantly.
- It prevents the "only one person knows how this works" problem.
- It increases capacity — without increasing emotional load.

A Reframing: Capacity, Not Headcount

The Jacobson data reframes the modernization narrative. Companies are not reducing staff. They are:

- Growing revenue
- Maintaining staffing
- Increasing hiring in many segments

This suggests something important: AI and automation are being deployed to increase throughput, improve accuracy, and expand service — not to eliminate roles. Or, as Kristen Crook put it when talking about fighting for her team:

"If you take something off their shoulders... then they have time to breathe."

That's the story the data supports. Automation in claims is not about replacing examiners. It's about freeing them.

Making Claims Better: Four Perspectives

So how do we start working towards a better future for carriers, examiners, and claimants?

Company-Wide Takeaways: Outcomes Every Department Should Align On

The Thread That Connects It All: Outcomes

Across every interview, one idea kept surfacing: outcomes matter more than activity.

For example, One carrier had a 10-day response SLA, meaning that no more than 10 days could go by before an examiner followed up on a claim and communicated with the claimant. On the surface, this sounds like a nice SLA, but it has a dark side. The claims examiners received a note every 7 or 10 days to respond on a claim, but they'd cross the next item on the claim checklist, which would then sit until the next touchpoint.

It actually takes much more time, more labor, and more cognitive load to pick work up on day 9 than on day 1. Had they taken more action up from on the claim, they'd have fewer calls, less playing catch-up as an examiner, less chasing, and ultimately, both a better claimant experience and less interest paid on claims.

Not:

- How many steps exist?
- How many systems are used?
- How much was digitized?

But:

- Did the claimant get paid quickly?
- Did the examiner's job get easier?
- Did the organization reduce risk instead of hard-coding it?

As Krista Eger, VP of Product at Benekiva put it:

"Every manual step earns its place in the process. Every rule should be intentional and every process needs to make life easier for people doing the work and the people that are waiting on it."

Let's look at claims outcomes that matter at every level of the company. Here are a few tips for making sure you're measuring success with the right metrics:

1. Base SLAs on the best possible outcome for the claimant

What does the claimant most need? Generally, the fastest possible claim experience with the fewest asks made of the claimant. If all relevant information can be gathered from a claimant up- front in the SLA or automatically pre-filled through integration, that would be great. It reduces back-and-forth, strain on the claimant, and time to process the claim.

SLAs should follow this best outcome for the claimant included turnaround time, percentage of claims straight-through processed, or even percentage of a claim that can be automated (i.e. pre-fill X% of data so that the claimant or examiner don't have to).

2. Never Rush Grief

A resounding note from claims leaders was to never rush conversations or interactions with claimants. It can be tempting to enact a time-limit on FNOL calls in the name of efficiency, but in the world of life, annuities, and living benefits claims, the person on the other end of the phone is often going through one of the hardest experiences of their life. Our job in claims is to provide care, dignity, and a listening ear for whatever they need.

If examiners are measured on volume and call-time caps, empathy gets squeezed out. You can't "culture" your way out of a throughput bottleneck. You have to remove non-value work so time exists for humans to be human.

Instead of judging efficiency in call center minutes, give teams tools that reduce the number of clicks they need to make, the number of documents and requirements they need to mentally track, the manual minutia of their job so they can spend the time where it matters most, with the people. Provide digital portals so that claimants can interact with you when and how they want to instead of spending time on hold. These digital processes reduce friction and enable examiners to provide the best possible experience in a claimant's moment of need.

3. Segment, don't penalize: isolate the small percentage of risk so the rest flows

As Steve Shaffer, CEO of Homesteaders Life put it:

"The biggest friction points are around building structures and processes around fraud prevention versus customer experience. But fraud is a relatively low percentage. Carriers end up holding up the 99.95% of claims that aren't fraudulent to catch the 0.05% of fraud cases."

Instead, carriers should segment claims, isolating the small percentage of risk so the rest, the majority, of claims flow smoothly.

a. Pay quickly by default
b. Triage exceptions

Homesteaders Life Company

4. Dedicate a Person or Team to Reducing Friction

Some of the best claims processes were driven by teams that included members focused exclusively on making the best, simplest experience possible for everyone involved.

Wellabe has taken a thoughtful approach to improving operations by focusing on reducing friction across the claims process. One example shared was analyzing how many clicks are required across workflows, from examiners to funeral home claimants to beneficiaries, and working to simplify and automate wherever possible. This intentionality led to Wellabe automating more than 65% of their claims.

BreAnna McGee, Business Analyst at Wellabe explained:

"My theory is every click I remove gives the team a little time and energy back, and that's a win for everyone. Less clicks is better. When we analyze why people get fatigue over applications, it's how many clicks they have to do in a day. More complicated screens might look more organized to a developer, but externally, that looks intimidating and scary. Less is more."

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Being Proactive With Claimants Can Actually Increase Revenue

A major opportunity for every carrier is to engage the claimant before a loss ever happens. Claimants are often forgotten since they come in at the tail end of a policy, but they have the potential to impact not just claims, but new business.

Consider that claimants frequently don't know how to use their policy, and many beneficiaries are unaware that a policy even exists, let alone that they're a beneficiary of said policy.

Here's one terrible beneficiary experience that was shared with us:

A woman was very sick, in the hospital on hospice care for months. During that time, she didn't pay her life insurance policy because she was sick in the hospital, leading that policy to expire. When the family member passed, the policy had lapsed, leaving her family in a tough place of having to pay for the funeral out of pocket. Ultimately, the family couldn't afford the funeral she had wanted. Had there been education for the beneficiaries, teaching them that:

1 There was a policy in place that needed to be paid

2 How to keep the policy active in the event the policyholder was unable to

3 How to use the policy when the time came

The family would've been able to plan for and afford the type of funeral the policyholder desired, and it would've saved countless years of friction that remained between the family members in the aftermath of the loss.

Yes, policyholders should talk to their family about their accounts and policies, but imagine how much company loyalty can be built by proactively taking care of claimants and beneficiaries long before a loss so that they feel prepared.

If a claimant or beneficiary has a good experience with your insurance company, they'll recommend you to their friends, their kids, their relatives.

Taking it one step further, if a million dollar claim payment appears in a beneficiary's account, how likely are they to actually know how to use it?

That's the perfect opportunity to guide them. Help them purchase an annuity guaranteeing income replacement. Help them purchase a life policy of their own. A great beneficiary experience can lead to a great acquisition experience as you're guiding them through what to do after a big loss.

"Carriers pay out billions in claims, payments, pension payments, across all different products. The capture rate for some of these huge carriers is only 3 to 4% in terms of you're paying out to a bank account, that asset is no longer in-house with you, the carrier.

Wouldn't it be really nice if you could provide a seamless digital experience that instead of paying out to the consumer-owned account, you could pay in right to another carrier product? It's a huge revenue potential there and opportunities and some of the dialogue that we're having in the market today."

Don't Silo Claims. It Weakens the Whole Company.

One of the clearest themes from our conversation with Rob Leary, Assistant Director of Individual Disability Claims Operations at Principal, was that claims should not operate as an island.

That may sound obvious, but in practice, claims is still too often treated as the back end of the business: important, but separate. Sales sells. Marketing markets. Product designs. Underwriting prices. Claims pays. Each function does its part, but not always in conversation with the others.

That separation comes at a cost.

When claims is siloed, other departments lose access to the people who understand most clearly how the product performs in real life. Claims teams see where policy language creates confusion, where riders fail to reflect actual loss, where brokers need more education, and where customers' hardest questions surface before a claim is ever filed. If those insights stay trapped inside claims, the rest of the organization loses one of its most valuable feedback loops.

Rob described Principal's culture as intentionally more open than most. Claims works hand-in-hand with underwriting, marketing, sales, and distribution. When brokers or prospective policyholders have highly detailed questions before buying a policy, claims is sometimes brought in directly. That level of openness is unusual, but it creates real value. It builds confidence in the product, strengthens service, and helps the organization learn faster.

It also improves the product itself.

Rob shared one example where claims experience directly informed product design: Principal had an overhead expense rider that, in practice, was not providing the level of protection they intended. Claims saw the gap first because they saw the real-world outcomes. By working with product, they were able to revise the rider so it better reflected actual loss rather than the theoretical version imagined when the language was first written.

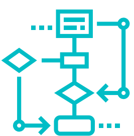
That is the case for breaking down silos. Claims is not just where the promise is fulfilled. It is where the truth about the promise becomes visible.

How to Build That Culture

Cultures like this do not happen by accident. They are built through repeated habits and structures, including:

Regular cross-functional meetings
Bring claims, product, underwriting, sales, distribution, and service together often enough that claims insight becomes part of how decisions get made.

Open access to expertise
Make it easy for other departments to reach claims with questions, especially on policy interpretation, customer scenarios, and broker education.



Claims involvement upstream
Pull claims into product and rider design conversations early, not just after problems surface.

Broker and partner education
Use claims leaders and reviewers as educators so those selling the product understand how it works when it matters most.

Feedback loops from real claims experience
Treat claims outcomes as product intelligence, not just operational output.

The broader lesson applies beyond claims. Any function that gets isolated loses influence, and any company that isolates key functions loses perspective. But claims may be the clearest example because it sits so close to the customer's moment of truth.

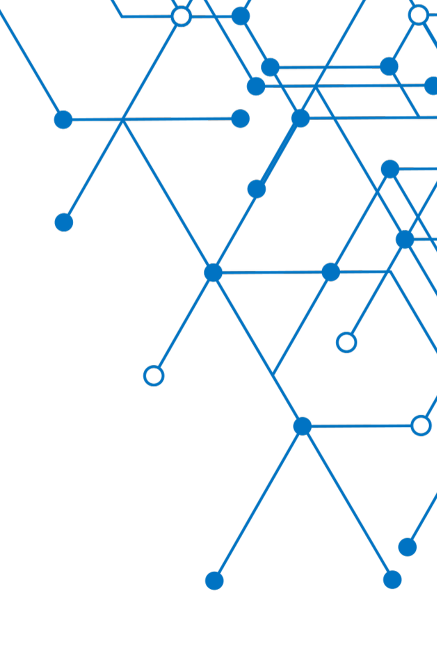
If companies want to provide world-class service, claims cannot just be informed by the rest of the business. The rest of the business must also be informed by claims.

Right the Claims Reputation

Claims can have a bad reputation, both within the insurance industry, and outside of it.

Particularly in the life, annuities, and living benefits space, claims can be seen as stingy and looking for any reason not to pay a claimant, a cost in carriers budgets, or even just morbid. People don't like talking about death.

Homesteaders Life's CEO Steve Shaffer described a mindset where claims isn't the back office — it is the product. Because every policy is tied to a prepaid funeral, "every one of our insurance policies has a claim," and speed is part of the promise. Shaffer argued that many insurers still build claims around "fraud prevention... versus customer experience," which creates friction for the vast majority of legitimate claims. His view: redesign claims so that paying quickly is the default, triage the true exceptions, and use AI to gather and validate information faster — not to replace human judgment or create new barriers for families.



People forget that claims are the actual insurance product, the delivery of the promise. Claims teams help people in crisis. Talk to any examiner, and they light up talking about the detective work involved, the puzzle they're trying to solve. Ask any claims examiner for their craziest claim story and you're in for a thrilling night of storytelling.

As Krista Eger, VP of Product at Benekiva puts it:

"It's fulfilling work. It's meaningful. You're helping people when they need it most."

Kathy Schmidt, a Claims Specialist at Sons of Norway said:

"I like to bring some joy to a person when they're going through the worst time of their life."

That purpose matters. It's what combats the burnout. It's important to affirm the importance of claims, to tell the good stories, not just the bad, internally and externally.

Executive Focuses

Transformation only works when leaders care

Claims modernization is a leadership issue before it is a technology issue. As Dodd Starbird, Managing Partner of Implementation Partners, LLC, puts it,

"If the leader isn't willing to stand in front of the room and say, 'we're doing this,' it won't work."

Dodd has overseen countless process transformations and technology implementations. They only work when they have an all-in, tuned-in executive sponsor.

Claims teams can often feel forgotten as the final part of a policy's lifecycle and an area typically associated with cost rather than new revenue. However, taking care of claims teams must be a top priority for any executive. Claims teams take care of people in their hardest moments of life, in huge grief. If an examiner is frustrated and overwhelmed, it leaks into their calls with claimants. Claimants are in grief; they interpret frustration as a lack of compassion. But when the team has breathing room, you hear laughter, rapport, warmth, and claimants feel cared for.

As Steve Shaffer, CEO of Homesteaders Life Insurance Company states:

"Claims is the value proposition. When someone buys insurance, what they're really buying is the promise that when the event occurs — a death, an illness, an accident — the company will show up and pay the claim. If you can't deliver that quickly and efficiently, you're failing the reason the policy exists.

Think about it like Amazon. If you ordered something online and they said, 'Thanks for your credit card. We'll get it to you in five months,' that wouldn't work. Customer expectations have changed, and insurance isn't immune to that. The companies that figure out how to deliver a fast, reliable claims experience are the ones that will win because if you fail people when it matters most, they won't come back and they'll tell others about it."

The undercover boss diagnoses

The best way to understand what your company's claims experience is like today is to test it yourself. We recommend every executive tries at least one of the two following litmus tests for claims experience:

Shadow a claims examiner for a day

This method requires time, but even if you spend just a morning with an examiner, watching what they do, seeing how many things they have to manually re-type or how many different systems it takes to log into in order to finish a claim, you'll have a new appreciation for their work and for claimants.

Submit a claim yourself

If spending a day shadowing a claims team member is out of the question, a low-effort, but highly effective strategy is to simply create a claim and see what happens. Use dummy policy data and a test environment if you have to, but try to submit a claim anonymously and time how long it takes, end-to-end. You'll be floored by the results.

Operations and Technology Focuses

Once carriers have taken an honest look at their processes, the next step is to evaluate the technology supporting them. Technology alone will not transform claims, but the wrong technology can quietly reinforce every inefficiency a team is already fighting.

That matters not only for productivity, but for talent. New entrants want meaningful work, and they want tools that work. Green screens, brittle systems, and workflows held together by spreadsheets are hard to sell in an interview. They are even harder to retain people in once the day-to-day reality sets in.

At the same time, perfection on day one is not the standard. Several leaders emphasized that there is real value in telling new hires, in effect: we're not perfect yet, but you can help us get there. For the right people, that is not a drawback. It is an invitation. The strongest organizations approach talent with an open mind, recognizing that while they may teach new hires the business, those new hires can also help push the business forward. The posture is not simply "join to operate." It is "join to modernize."

That mindset becomes especially important when deciding what to automate. Simple, repeatable claims should move as quickly and cleanly as possible. Straight-through processing can be a game changer here.

As BreAnna McGee of Wellabe explained, once a claim has to be manually reviewed and touched instead of being straight-through processed, it starts costing the company money. For that reason, the goal should be to straight-through process as many routine claims as possible and reserve examiner expertise for the cases that truly require judgement.

The same principle applies to document handling. If a carrier is asking an employee to spend eight hours a day manually reading PDFs to extract a date of death, a claimant name, or other standard fields, that is not a good use of human skill. OCR and related extraction technologies are not glamorous, but they are often among the clearest opportunities to reduce friction immediately. They free up examiner time, reduce repetitive strain, and allow experienced staff to focus on investigation, decisioning, and claimant support instead of transcription work.

Why MVP Is Quietly Killing Transformation

A recurring theme in these conversations was the danger of treating transformation like a one-time event instead of an ongoing discipline. Many stalled modernization efforts begin with good intentions, but quickly get boxed into a "minimum viable product" mindset that leaves too much unfinished.

As Robert Mattioda, CEO of The Life and Annuities Group, put it:

"MVP is what happens when nobody did the work upfront. A phased implementation is strategic. MVP is reactive."

That distinction matters. A phased implementation has a clear destination and an intentional roadmap. It breaks the work into manageable pieces without losing sight of the whole. A reactive MVP, by contrast, often becomes a shortcut around the deeper process and design work transformation actually requires.

Mike Fidler of One Inc. described the healthier alternative:

"Carriers often want to 'boil the ocean,' but that approach can feel overwhelming. We always encourage them to start small, focusing on the area that will deliver the greatest impact for their investment. From there, we can tackle the rest, one piece at a time."

That is a very different philosophy from stopping at partial modernization and calling it complete. Because that is where many carriers get stuck: with an 80% modernized process and the remaining 20% still living in old systems, side processes, and tribal knowledge.

BreAnna McGee captured that frustration directly:

"I understand the 80/20 rule but don't agree with it. You may automate 80% of claims, but you end up with even more system and knowledge sprawl."

That unfinished 20% creates more damage than many organizations expect. It turns one or two people into the keepers of the old way. It preserves old systems long after the organization believes it has moved on. It slows training, increases audit overhead, and introduces risk whenever unusual scenarios arise.

Jim Girard, VP of Engineering at Benekiva, described the problem plainly: when edge cases are perpetually deferred, the unfinished 20% becomes a second system built out of workarounds, spreadsheets, and institutional knowledge. "The 20% requires twice as much time and twice as much money," he said. "So people don't do it."

The issue is not that teams start small. The issue is that they stop there. Most organizations may never achieve perfect 100% coverage, but they can continuously shrink the gap. That takes people who understand both the business and the technology well enough to prioritize the right problems, make thoughtful tradeoffs, and keep moving instead of declaring victory too early.

Buy vs. Build: A Debate with Real Consequences

One of the most practical technology questions carriers face is whether to buy a claims platform or build one themselves. For some leaders, the answer is straightforward.

As Robert Mattioda put it:

"Nobody should ever build. You should build tools around the system, not build the core platform. Someone has already built the wheel; no need to reinvent it. Carriers don't have the architectural depth vendors have, and they shouldn't try to. Even worse, I see carriers spend $450k by automating a 1% edge case, when they could've just used a core system and built an edge tool to support the 1% edge case. Vendors have already invested millions in generalized workflows. Align processes to the platform, not the other way around."

That perspective reflects a broader lesson from these interviews: carriers often create unnecessary complexity when they insist that a new platform mirror every legacy process exactly. In many cases, the more valuable move is to adopt a strong core system and then build lightweight tools around the edges where truly unique needs exist. Trying to rebuild the entire core usually drains time, money, and focus away from the problems that matter most.

AI Won't Save Broken Processes — But It Will Magnify Old Ones

No conversation about claims transformation is complete without addressing AI. But across these interviews, the most useful perspective on AI was also the most grounded: AI is not a strategy on its own.

Too many organizations start with the board mandate instead of the business problem. They know they need an AI story, but they cannot clearly articulate what AI should actually do. That is where trouble starts. AI should begin with a defined operational need, not a vague executive directive.

That also means carriers need systems that are genuinely AI-ready: API-ready, modular, interoperable, and structured in a way that allows data to move cleanly between systems. Without that foundation, AI becomes another layer sitting on top of process chaos.

Several interviewees also raised a note of caution about the market itself. Carriers should be skeptical of vendors rebranding older automation features as "AI." They should ask to see AI in action, not just in slides and on websites. The question is not whether a vendor has an AI message. The question is whether the technology solves a real claims problem in a practical, measurable way.

Right now, one of the clearest opportunities appears to be in assisting—not replacing—human judgment. For example, summarizing massive medical records in contestable claims can save significant examiner time and reduce manual review burden without handing final decision-making over to a machine. It can also assist with triaging to make sure that the right claims are prioritized.

Chris Stanley, VP of Underwriting at Bankers Fidelity made that distinction clearly:

"We can't have AI making decisions on our behalf, but AI can enhance the process: summarize, identify what's missing, and save examiner time."

He also pointed to the value of AI "in the in-between," handling missing-detail requests and reducing examiner involvement in routine follow-up steps.

Steve Schaffer, CEO of Homesteaders Life, struck a similar note: "Using AI... to process and gather data more quickly... rather than letting the AI do the work." His advice was simple and direct: "Just slapping AI on top of your claims process is not probably a good strategy... [use it] to remove friction and bottlenecks."

That may be the most important principle of all. AI is most useful when it removes friction, accelerates information gathering, and supports human expertise. It is far less useful when treated as a shortcut around process design, operational discipline, or examiner judgment.

The bigger long-term issue may not be automation alone, but the way AI changes fraud behavior and customer behavior. As the technology evolves, carriers will need to think not only about how AI helps process claims, but also how it changes the ecosystem in which claims happen. That makes foundational process clarity, strong systems, and disciplined human oversight even more important.

Claim Leader Focuses

Talking to a variety of claims leaders, three common problems and pieces of advice surfaced:

The Challenge of Executive Buy-In

If you've read this far in the report, and you're a claim leader, you may be thinking, I live this every day, but I can't make these changes unless leadership gets on board, and they'll never agree to the time, money, and resources change will require.
You are not alone in this battle.

As one claims leader described,

"Almost every claim professional I've spoken to has had difficulty getting the C-Suite level senior leadership to understand that investment in claims is a necessity. Leadership always assumes we'll 'get to it at some point.' It's easier to focus on increasing sales, profit margins, staying 'competitive and relevant' in the industry. The money goes into the underwriting tools, policy issuance, acquisition. It doesn't go to servicing, and certainly not to claims operations. But there's a push lately to have higher interest savings, to automate so that we can offer a better customer experience and a better bottom line for our company."

As Robert Mattioda, CEO of The Life and Annuities Group says,

"Claims modernization is a hard sell internally because it looks like money going out, not money coming in."

Your job as a claims team or leader is to reset the narrative. Here are some tips and steps to start creating ripples to make a tide of change at your company.

At the end of the day, every executive cares about three things:

1
Reduce cost
(operational expense, leakage, interest, rework)

2
Increase revenue
(retention / cross-sell / persistency / advisor experience)

3
Reduce tech debt & risk
(complexity, brittleness, key-person dependency)

Before talking to your executives, we recommend getting a pulse for each of the following areas below, understanding what you pay today and how this could be reduced if the process and technology went through transformation.

Interest payments
Carriers have saved millions of dollars in interest payments by accelerating claim turn-around time. We've also talked to claims teams who don't even know what their interest payments cumulate to, for example if it's in finance's budget. This is one of your strongest financial levers for life and annuity claims transformation. Knowing this number and how automation can reduce it can be the difference between whether or not an executive signs off.

Printing and mailing costs
Moving from printing and mailing every piece of correspondence to emailing, texting, or offering digital portals with real-time updates can save hundreds of thousands of dollars in costs and tens of thousands of hours for the team drafting, printing and mailing documents. Imagine repurposing 10 full-time-employees from stuffing envelopes to value-adding activities like talking to claimants or even to other departments like new business.

Call center costs
Offering a digital portal for submitting an FNOL or a digital portal for document upload and claim status can save countless status and FNOL phone calls, as well as back-and-forth securing documents.

A Tier 1 carrier using Benekiva's servicing solution was able to reduce 47% of NIGOs by enabling policyholder and claimant self-service on their life claims, eliminating 200,000 phone calls a year and saving their team more than 23,000 hours each year.

Outgoing payments
Automating outgoing payments can have a big impact, not just on print and mailing costs associated with sending checks, but also in time saving as claimants have fewer calls asking where their payment is.

One Inc worked with a carrier to offer virtual cards to 75% of their funeral homes. Between the time savings, rebates, and interest reduction, the carrier saw a 45% reduction in calls made to the call center and up to $3.2 million savings for them.

Straight-through processing Imagine how much time could be saved if you could automate 10% of claims? Or 20%? Or even 40%? We've seen teams able to take on additional claims capacity without adding headcount by automating claim and document processing.

Transform, Don't Just Digitize.

Many claims leaders have worked in their field for decades. They are experts of their craft and know claims inside and outside.

The dark side of that experience is that it's easy to fall into a mindset of doing things they way you've always done them.

We see this frequently with carriers that we talk to about claims transformation. There is a tendency to want to digitize their processes - doing the exact same thing on a screen, rather than transforming them.

When we think about the evolution of the cell phone, it started as a digitization of sorts of a home phone, making phone calls portable. But then it evolved into much more than that. It offered texting as a short form of communication, evolving with the medium.

In the same sense, claims processes must evolve and transform with the medium or technology being used.

But that transformation is hard. It requires questioning why every process exists and if there's a better or easier way to fit this new medium.

As claims leaders, it's important to guide teams to transform first, refining processes, and then digitize what you've transformed.

Krista Eger, VP of Product at Benekiva says,

"If you automate chaos, you get chaos faster."

"Unsuccessful digital transformation is not a technology problem. It's a clarity problem," says Mattioda, CEO of The Life and Annuities Group. "Unclear goals, unclear outcomes, poor requirements, unrealistic expectations, and poor governance all keep transformation from ever getting off of the ground, let alone successfully carried out."

If you're looking to start transformation, here are some guiding principles:

Customer Experience is always the most important focus.

If customer experience doesn't improve or if claims examiners' work doesn't get easier, then nothing was truly transformed. The organization simply digitized a broken process.

Start with decisioning, not UI or forms.

If decision trees or the reason we make those decisions are unclear, everything slows down. Claims bounce between examiners, supervisors and QI, not because complexity demands it, but but because confidence is missing. Clear decision logic unlocks speed, examiner confidence, better QA, reduced rework, and lower fear.

As Krista Eger, VP of Product at Benekiva says, "If a process needs a human to remember how it's completed, it's already a broken process."

Go through every single process to determine if they truly belong in a modern system.

Here are some questions to guide you on whether or not a process belongs.

- What risk does this step actually mitigate?
- Who benefits from this step—the organization or the customer?
- What happens if we remove it?
- Is this step based on policy, regulation, or habit?
- If we designed this process today, would we still do it this way?

If the answers aren't clear or can't be confidently explained, that step is a strong candidate for removal or redesign.

Avoid fake transformation red flags.

As you ask these questions of your team and your processes, certain criteria can tip that the thinking behind a process may need to be updated to accommodate the new system:

- We've always done it that way.
- Compliance requires it, but no one can prove it
- We just need the system to match our checklist
- Excessive required fields "just in case" for the once-every-ten-years corner cases
- Edge cases driving core design
- Duplicate validation steps with no value added
- Multiple handoffs, unclear ownership
- Fear (not outcome) driven design

Afterwards, measure if the transformation actually worked. Here are a few clear signs that the transformation worked:

- The process is actually faster in real life (not just on paper)
- There are fewer handoffs Rework decreases
- Examiners understand what's expected
- Team members aren't still building spreadsheets on the side
- Examiners would actually choose this process, they aren't just stuck with it.

If these are not true, then your transformation isn't done yet.

Always be transforming.

A final thought: with the pace of change in technology and AI today, we are all continually transforming, refining, and adopting the best of new technology. There's always room to grow, and that's a good thing. It's what makes us human.

In Summary

Dodd Starbird, Managing Partner of Implementation Partners, LLC summarized it best:

"Ultimately, there's a human component more important than any cost benefit analysis a claims leader could create that we often forget. The whole reason life insurance exists is to help people in crisis. Is it okay to make someone wait 10, 20, 30, 60 days after their loved one died for a follow-up or claim payout?

You're fulfilling a promise in someone's hardest moment. You should challenge the idea that the current way is acceptable and ask yourself: how can we do this different?"

If you're looking to transform your claims experience, start with a conversation.

Every organization is at a different point in its journey. Whether you're rethinking processes, evaluating technology, or trying to build alignment internally, the first step is clarity.

We're always happy to share what we're seeing across the industry and help you think through what transformation could look like for your team.

Request a demo

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