बीमा विनियामक और विकास प्राधिकरण
INSURANCE REGULATORY AND DEVELOPMENT AUTHORITY

No.IRDA/SDD/MISC /CIR/ 009/ 01/2013 January 21, 2013

To CEOs of all Insurance and Reinsurance Companies

Insurance Fraud Monitoring Framework

A. Introduction:

Financial Fraud poses a serious risk to all segments of the financial sector. Fraud in insurance reduces consumer and shareholder confidence; and can affect the reputation of individual insurers and the insurance sector as a whole. It also has the potential to impact economic stability. It is, therefore, required that insurers understand the nature of fraud and take steps to minimize the vulnerability of their operations to fraud. Due measures also have to be laid down to address possible frauds in each line of business viz., life, general and health as threats/vulnerabilities posed under each one of them vary significantly.

Under the Regulatory Framework put in place for insurance companies, the Authority has stipulated a number of measures to be taken by insurance companies to address the various risks faced by them. Some of these include:

- The Corporate Governance guidelines mandate insurance companies to set up a Risk Management Committee (RMC). The RMC is required to lay down the company-wide Risk Management Strategy.
- As part of the Responsibility Statement which forms part of the Management Report filed with the Authority under the IRDA (Preparation of Financial Statements and Auditors' Report of Insurance Companies) Regulations, 2002, the management of an insurance company is required to disclose the adequacy of systems in place to safeguard the assets for preventing and detecting fraud and other irregularities, on an annual basis.

In order to provide regulatory supervision and guidance on the adequacy of measures taken by insurers to address and manage risks emanating from fraud, the Authority has laid down the guidelines requiring insurance companies to have in place the Fraud Monitoring Framework.

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Fraud Risk Management Systems for Reinsurer:

Reinsurers can reduce their exposure to fraudulent claims from ceding insurers and reinsurance intermediaries by understanding the fraud risk management systems these counterparties have in place. Accordingly, these guidelines apply *mutatis mutandis* in case of Reinsurers.

The Guidelines mandate insurance companies to put in place, as part of their corporate governance structure:

(i) fraud detection and mitigation measures; and
(ii) submit periodic reports to the Authority in the formats prescribed herein.

All insurers are required to ensure that the risk management function is organized in such a way that the insurer is able to monitor all the risks across all lines of business on a continuing basis and to initiate measures to address them suitably.

B. Scope and Classification of Insurance Frauds:

Fraud in insurance is an act or omission intended to gain dishonest or unlawful advantage for a party committing the fraud or for other related parties. This may, for example, be achieved by means of:

- misappropriating assets;
- deliberately misrepresenting, concealing, suppressing or not disclosing one or more material facts relevant to the financial decision, transaction or perception of the insurer's status;
- abusing responsibility, a position of trust or a fiduciary relationship.

In order to adequately protect itself from the financial and reputational risks posed by insurance frauds, every insurance company shall have in place appropriate framework to detect, monitor and mitigate occurrence of such insurance frauds within its company. The said framework shall, at the minimum, include measures to protect the insurer from the threats posted by the following broad categories of frauds:

a) *Policyholder Fraud and/or Claims Fraud* - Fraud against the insurer in the purchase and/or execution of an insurance product, including fraud at the time of making a claim.

b) *Intermediary Fraud* - Fraud perpetuated by an insurance agent/Corporate Agent/intermediary/Third Party Administrators (TPAs) against the insurer and/or policyholders.

c) *Internal Fraud* – Fraud/ mis-appropriation against the insurer by its Director, Manager and/or any other officer or staff member (by whatever name called).

An illustrative list of Insurance Frauds is given at Appendix – 1. These instances include frauds perpetuated internally; by insurance agent/Corporate Agent/intermediary/TPAs; and instances of claims/policyholder frauds.

For more examples please refer to http://www.iaisweb.org

C. Anti-Fraud Policy:

All insurance companies are required to have in place an Anti Fraud Policy duly approved by their respective Boards. The Policy shall duly recognize the principle of proportionality and reflect the nature, scale and complexity of the business of specific insurers and risks to which they are exposed. While framing the policy, the insurance company should give due consideration to all relevant factors including but not limited to the orgainsational structure, insurance products offered, technology used, market conditions, etc. As fraud can be perpetrated through collusion involving more than one party, insurers should adopt a holistic approach to adequately identify, measure, control and monitor fraud risk and accordingly, lay down appropriate risk management policies and procedures across the organization.

The Board shall review the Anti Fraud Policy on atleast an annual basis and at such other intervals as it may be considered necessary.

The anti-fraud policy shall broadly cover the following aspects:

i. Procedures for Fraud Monitoring:

Well-defined procedures to identify, detect, investigate and report insurance frauds shall be laid down. The function of fraud monitoring shall be either an independent function or can be merged with existing functions like risk, audit etc., The Head of this function should be placed at sufficiently senior management level and should be able to operate independently.

ii. Identify Potential Areas of Fraud:

Identify areas of business and the specific departments of the organization that are potentially prone to insurance fraud and lay down a detailed department-wise, anti-fraud procedures. These procedures should lay down the framework for prevention and identification of frauds and mitigation measures.

iii. Co-ordination with Law Enforcement Agencies:

Lay down procedures to coordinate with law enforcement agencies for reporting frauds on timely and expeditious basis and follow-up processes thereon.

iv. **Framework for Exchange of Information:**

Lay down procedures for exchange of necessary information on frauds, amongst all insurers through the Life and General respective councils. The insurance companies are well advised to establish coordination platforms through their respective Councils and/or Forum to establish such information sharing mechanisms.

v. **Due Diligence:**

Lay down procedures to carry out the due diligence on the personnel (management and staff)/ insurance agent/ Corporate Agent/ intermediary/ TPAs before appointment/ agreements with them.

vi. **Regular Communication Channels:**

Generate fraud mitigation communication within the organization at periodic intervals and/or adhoc basis, as may be required; and lay down appropriate framework for a strong whistle blower policy. The insurer shall also formalize the information flow amongst the various operating departments as regards insurance frauds.

D. **Fraud Monitoring Function (FMF):**

The FMF shall ensure effective implementation of the anti-fraud policy of the company and shall also be responsible for the following:

i. Laying down procedures for Internal reporting from/and to various departments.

ii. Creating awareness among their employees/ intermediaries/ policyholders to counter insurance frauds.

iii. Furnishing various reports on frauds to the Authority as stipulated in this regard; and

iv. Furnish periodic reports to their respective Board for its review.

E. **Reports to the Authority:**

The statistics on various fraudulent cases which come to light and action taken thereon shall be filed with the Authority in forms FMR 1 and FMR 2 providing details of

(i) outstanding fraud cases; and
(ii) closed fraud cases

every year within 30 days of the close of the financial year.

F. Preventive mechanism:

The Insurer shall inform both potential clients and existing clients about their anti-fraud policies. The Insurer shall appropriately include necessary caution in the insurance contracts/ relevant documents, duly highlighting the consequences of submitting a false statement and/or incomplete statement, for the benefit of the policyholders, claimants and the beneficiaries.

G. Insurer's to Ensure Compliance:

The stipulations on fraud detection, classification, monitoring and reporting by the insurers shall be effective from the financial year 2013-14. A compliance certificate confirming laying down of appropriate procedures shall be submitted by 30th June 2013.

(J. HARI NARAYAN)
Chairman

Appendix – 1

Illustrative List of Insurance Frauds

Broadly, the potential areas of fraud include those committed by the officials of the insurance company, insurance agent/corporate agent/intermediary/TPAs and the policyholders/ their nominees. Some of the examples of fraudulent acts/omissions include, but are not limited to the following:

1. Internal Fraud:

   a) misappropriating funds
   b) fraudulent financial reporting
   c) stealing cheques
   d) overriding decline decisions so as to open accounts for family and friends
   e) inflating expenses claims/over billing
   f) paying false (or inflated) invoices, either self-prepared or obtained through collusion with suppliers
   g) permitting special prices or privileges to customers, or granting business to favoured suppliers, for kickbacks/favours
   h) forging signatures
   i) removing money from customer accounts
   j) falsifying documents
   k) selling insurer's assets at below their true value in return for payment.

2. Policyholder Fraud and Claims Fraud:

   a) Exaggerating damages/loss
   b) Staging the occurrence of incidents
   c) Reporting and claiming of fictitious damage/loss
   d) Medical claims fraud
   e) Fraudulent Death Claims

3. Intermediary fraud:

   a) Premium diversion-intermediary takes the premium from the purchaser and does not pass it to the insurer
   b) Inflates the premium, passing on the correct amount to the insurer and keeping the difference
   c) Non-disclosure or misrepresentation of the risk to reduce premiums
   d) Commission fraud - insuring non-existent policyholders while paying a first premium to the insurer, collecting commission and annulling the insurance by ceasing further premium payments.

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FMR – 1

Fraud Monitoring Report

Name of the Insurer:
Report for the year ending

Part I

Frauds Outstanding- Business segment wise *:

Sl. No.	Description of Fraud	Unresolved Cases at the beginning of the year		New cases detected during the year		Cases closed during the year		Unresolved Cases at the end of the year	
		No.	Amount involved (₹ lakh)	No.	Amount involved (₹ lakh)	No.	Amount involved (₹ lakh)	No.	Amount involved (₹ lakh)
	Total								

Part II

Statistical details: (unresolved cases as at end of the year) –Business segment wise*

Sl. No.	Description of Fraud	No. of Cases	Amount Involved (₹ lakh)
	Total		

Part III

Preventive and Corrective steps taken during the year- Business segment wise*

Sl.No.	Description of the fraud	Preventive/Corrective action taken

Part IV

Cases Reported to Law Enforcement Agencies

Sl. No.	Description	Unresolved Cases at the beginning of the year		New cases reported during the year		Cases closed during the year		Unresolved cases at the end of the year	
		No.	₹ lakh	No.	₹ lakh	No.	₹ lakh	No.	₹ lakh
	Cases reported to Police								
	Cases reported to CBI								
	Cases reported to Other agencies (specify)								
	Total								

* Business segments shall be as indicated under IRDA (Preparation of Financial Statements and Auditor's Report of Insurance Companies) Regulations, 2002

CERTIFICATION

Certified that the details given above are correct and complete to the best of my knowledge and belief and nothing has been concealed or suppressed.

Date:
Place:

Signed/-
Name of the Chief Executive Officer of the Insurer

FMR – 2

Fraud Cases closed during the year

Name of the Insurer: Report for the year ending

Sl. No.	Basis of closing a case	Number of cases closed
1.	The fraud cases pending with CBI/Police/Court were finally disposed off	
2.	The examination of staff accountability has been completed	
3.	The amount involved in the fraud has been recovered or written off	
4.	The insurer has reviewed the systems and procedures; identified the causative factors; has plugged the lacunae; and the portion taken note of by appropriate authority of the insurer (Board, Committee thereof)	
5.	Insurer is pursuing vigorously with CBI for final disposal of pending fraud cases, staff side action completed. Insurer is vigorously following up with the police authorities and/or court for final disposal of fraud cases	
6.	Fraud cases where: The investigation is on or challan/ charge sheet not filed in the Court for more than three years from the date of filing of First Information Report (FIR) by the CBI/Police; or Trial in the courts, after filing of charge sheet / challan by CBI / Police has not started, or is in progress.	

CERTIFICATION

Certified that the details given above are correct and complete to the best of my knowledge and belief and nothing has been concealed or suppressed.

Date:
Place:

Signed/-
Name of the Chief Executive Officer of the Insurer

Closure of Fraud Cases:

For reporting purposes, only in the following instances of fraud cases can be considered as closed:

1. The fraud cases pending with CBI/Police/Court are finally disposed of.
2. The examination of staff accountability has been completed
3. The amount of fraud has been recovered or written off.
4. The insurer has reviewed the systems and procedures, identified the causative factors and plugged the lacunae and the fact of which has been taken note of by the appropriate authority of the insurer (Board / Audit Committee of the Board)
5. Insurers are allowed, for limited statistical / reporting purposes, to close those fraud cases, where:

    a. The investigation is on or challan/ charge sheet not filed in the Court for more than three years from the date of filing of First Information Report (FIR) by the CBI/Police, or
    b. The trial in the courts, after filing of charge sheet / challan by CBI / Police, has not started, or is in progress.

Insurers should also pursue vigorously with CBI for final disposal of pending fraud cases especially where the insurers have completed the staff side action. Similarly, insurers may vigorously follow up with the police authorities and/or court for final disposal of fraud cases and / or court for final disposal of fraud cases.