Monetary Authority of Singapore

INSURANCE BUSINESS
- INSURANCE FRAUD RISK

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GUIDELINES ON RISK MANAGEMENT PRACTICES FOR INSURANCE BUSINESS - INSURANCE FRAUD RISK

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1 INTRODUCTION AND FUNDAMENTALS

1.1 INTRODUCTION

1.1.1 The International Association of Insurance Supervisors (IAIS) recognises the importance for insurers to address the potential implications of insurance fraud on their operations. In this regard, one of the IAIS' Insurance Core Principles recommends that supervisors require insurers to take necessary measures to prevent, detect and remedy insurance fraud. The IAIS also issued a guidance paper in October 2006 setting out guidelines for mitigating insurance fraud risk.

1.1.2 This chapter provides guidance on sound risk management practices to identify and mitigate direct insurers' exposure to the risk of insurance fraud. It articulates broad principles that should be embedded in a risk management framework covering strategy, organisational structure, policies and procedures for managing insurance fraud risk. It incorporates the guidelines from the IAIS Guidance Paper on Preventing, Detecting and Remedying Fraud in Insurance.

1.1.3 This chapter should be read in conjunction with other relevant guidelines issued or to be issued by the MAS, in particular "Guidelines on Outsourcing" (updated in July 2005), "Guidelines on Corporate Governance for Banks, Financial Holding Companies and Direct Insurers which are Incorporated in Singapore" (issued in September 2005), and "Guidelines on Risk Management Practices" (issued in February 2006).

1.1.4 Insurers are encouraged to adopt the sound practices recommended in this chapter and the other guidelines where applicable and to the level that is commensurate with the institutions' risk and business profiles.

1.2 FUNDAMENTALS

1.2.1 Fraud can be defined as an act or omission intended to gain dishonest or unlawful advantage for the party committing fraud or for other related parties. In the case of insurance fraud, this would usually involve an exaggeration of an otherwise legitimate claim, premeditated fabrication of a claim and/or fraudulent misrepresentation of material information.

1.2.2 Insurers rely greatly on the accuracy and completeness of information provided by policyholders, claimants and intermediaries when underwriting risks and processing claims. However, they face various constraints in verifying the legitimacy of the information provided due to

factors such as high volume of transactions (for some insurance products), complexity of circumstances leading to a claim and asymmetric information.

1.2.3 Insurance fraud can pose serious risk to insurers and may result in significant costs to its stakeholders. If prevalent and not mitigated, insurance fraud can potentially affect the financial soundness of individual insurers and erode both consumers' and shareholders' confidence in these insurers as well as the insurance sector at large.

1.2.4 The broad categories of fraud would include:

- **policyholder and claims fraud -** fraud against the insurer by the policyholder and/or other parties in the purchase and/or execution of an insurance product;
- **intermediary fraud -** fraud by intermediaries[1] against the insurer and/or policyholders; and
- **internal fraud –** fraud against the insurer by its director or employee on his/her own or in collusion with parties internal or external to the insurer.

1.2.5 The scope of this chapter is limited to policyholder and claims fraud as well as intermediary fraud. For guidance on risk management practices to mitigate risk of internal fraud, insurers should refer to the "Guidelines on Risk Management Practices – Internal Controls" issued by the MAS in February 2006.

1.2.6 Although certain categories of insurance intermediaries are licensed by MAS, an insurer should still assess each and every intermediary based on the intermediary's track record and the insurer's past experience in its dealings with the intermediary. Based on that assessment, the insurer should apply the appropriate risk management measures in respect of transactions involving an intermediary, regardless of whether it is licensed by MAS.

1.2.7 As fraud can be perpetrated by collusion involving a few parties, an insurer should adopt a holistic approach to adequately identify, measure, control and monitor fraud risk and embed appropriate risk management policies and procedures into its processes across the organisation.

[1] For the purposes of this chapter, intermediaries would include the insurer's tied agents, financial advisory firms and insurance brokers (where applicable).

2 RISK MANAGEMENT FRAMEWORK

2.1 STRATEGY

2.1.1 An insurer should have a sound strategy to manage fraud risk arising from its operations. The fraud management strategy should form part of an insurer's business strategy and be consistent with its overall mission, business strategy and objectives. It should:

- include a clear mission statement to indicate the insurer's level of tolerance to fraud;
- facilitate the development of quantitative risk tolerance limits on fraud; and
- provide direction to the overall fraud management plan.

2.1.2 A sound and prudent fraud management strategy must be compatible with the risk profile of the insurer. In determining its risk profile as well as its vulnerability to fraud, insurers should consider the following factors:

- size, composition and volatility of its business;
- organisational structure;
- complexity of its operations;
- products and services offered;
- remuneration and promotion policies;
- distribution modes; and
- market conditions.

2.1.3 To ensure its relevance and adequacy, the strategy should be reviewed regularly to ensure that it continues to be effective, especially when there are material changes to the insurer's risk profile. The strategy should also be properly documented and effectively communicated to all relevant staff. There should be a process to approve proposed deviations from the approved strategy, and systems and controls to detect unauthorised deviations.

2.2 STRUCTURE

2.2.1 An insurer should adopt a risk management structure that is commensurate with the size and nature of its activities. The organisational structure should facilitate effective management oversight and execution of its fraud risk management and control processes. The structure should facilitate communication between departments and to senior management and/or the Board of Directors to ensure prompt responses to instances or suspicions of fraud.

2.2.2 The Board is ultimately responsible for the sound and prudent management of fraud risk. It should recognise and understand the risk of fraud and its potential impact on the institution.

2.2.3 The Board should approve the fraud management strategy and ensure that adequate resources, expertise and support are provided for the effective implementation of the insurer's fraud management strategy, policies and procedures. Any deviation from the approved strategy and policies should be subject to the Board's review and approval.

2.2.4 An insurer should consider establishing a fraud management function if warranted by its risk assessment. This function would be primarily responsible for the compliance with the insurer's fraud management policies and procedures covering fraud identification, reporting and investigations. In order to be effective, this function should have the requisite authority, sufficient resources and be able to raise issues directly to the Board or relevant Board Committee.

2.3 POLICIES AND PROCEDURES

2.3.1 An insurer should establish clear policies and procedures for the management of fraud risk. These policies should be well-defined and consistent with the insurer's fraud management strategy, as well as adequate for the nature and complexity of its activities. These include:

- the roles and responsibilities of the fraud management function or staff assigned to execute the insurer's fraud management strategy, policies and procedures;
- measures to identify and mitigate the risk of fraud;

- measures to monitor and detect instances or suspicion of fraud;
- reporting of suspicions of fraud to designated person(s) for review and investigation;
- record keeping of suspicions of fraud and fraud cases; and
- relevant initial and ongoing training on fraud matters for its directors, management and staff.

2.3.2 The insurer should retain records of all reported cases of suspicion/incident of fraud together with internal findings and analysis done in relation to them. It should establish standards relating to the turnaround time for the assessment of fraud, documentation of analysis, and keeping of records on suspicions/incidents of fraud. The insurer should specify in its policies and procedures in respect of record keeping the following:

- information and analysis to be recorded;
- retention period; and
- staff access to records based on their confidentiality classification.

2.3.3 The insurer's anti-fraud policies should be communicated throughout the organisation. An insurer should also review the effectiveness of its policies, taking into account changing internal and external circumstances as well as identification of lessons from incidents of fraud or suspicions of fraud to enhance its management of fraud risk. Policies and procedures should be documented and set out in sufficient detail to provide operational guidance to staff.

2.3.4 The insurer should have in place proper and effective reporting systems to satisfy the requirements of the Board with respect to reporting frequency, level of detail, usefulness of information and recommendations to address issues of concern. There should be clear guidelines on the type of information to be reported to the Board on a regular basis as well as when certain information or development ought to be communicated immediately to the Board.

3 RISK IDENTIFICATION, CONTROL AND MONITORING

3.1 RISK IDENTIFICATION AND MEASUREMENT

3.1.1 An insurer should assess its activities and processes for any vulnerability to fraud and determine the consequential impact of any potential fraud. In determining the potential sources of fraud risk, the insurer should consider the following:

- adequacy of measures to verify customer information before accepting a customer's proposal taking into consideration the risk factors posed by different distribution channels such as internet policy application without face-to-face contact; and
- fit and proper standards for its intermediaries.

3.1.2 The insurer should also recognise that certain products or lines of business may be more susceptible to particular types of fraud. For instance, for workman compensation insurance, employers may misrepresent their employees' payroll and job scope in order to pay lower premiums. Similarly, motor insurance is susceptible to inflated claims as well as staging of accidents so that policyholders and/or workshops can obtain more compensation from insurers. The insurer should also identify fraud risk factors in product design during the early stages of product development.

3.1.3 The insurer should establish appropriate indicators that when triggered, suggests a higher risk of fraud. In the event that one or more indicators are triggered, the insurer should ascertain the facts to determine whether a more in-depth investigation and follow up actions are warranted. There should be adequate documentation of the verification actions taken. The indicators should be reviewed regularly for their continued relevance and effectiveness in detecting fraud.

3.1.4 Common indicators that could be used in the identification of fraud risk may include:

<u>Policyholder and Claims Fraud</u>

- policyholder has been declined coverage by other insurers due to reasons such as non-disclosure of material information;
- claimant is willing to settle claims for an inexplicably low settlement amount in exchange for a quick resolution;

- claimant provides inconsistent statements or information to relevant parties such as the insurer or police; and

- claimant made several claims of similar nature within a relatively short period of time;

Intermediary Fraud

- evidence of churning of policies either within the organisation or across several product providers;

- large number of policies in the intermediary's portfolio that have arrears in premium payments, unusual product-client combinations such as instances where the policyholder's income is not likely to be able to support the premium he/she has to pay for the product purchased and/or previous instances of fraud;

- customer complaints against the intermediary, including allegation of mishandling of monies and non-receipt of policy documents from the intermediary when the documents have been issued by the insurer;

- customers' records are not in the insurer's customer database even though proposal documents and/or payment have been provided to the intermediary some time ago; and

- indications that suggest that the intermediary is in financial distress.

3.2 RISK CONTROL AND MITIGATION

Policyholder and Claims Fraud

3.2.1 An insurer should also establish an adequate client acceptance policy, which should include the categorisation of usual product-client combinations. For example, insurers could categorise the customers based on expected earning and other factors for certain products in order to identify any unusual product-client combinations. For each combination, the insurer should set out clear conditions for the acceptance of the client's proposal and the appropriate measures to mitigate or detect fraud. A typical client acceptance policy would also include one or more of the following:

- Customer Due Diligence ("CDD") measures to be taken before business relationship is established for various product types; and
- measures to be taken for unusual product-client combinations including the request for additional supporting documents. For instance, the insurer may request for additional information to verify whether the policyholder has other sources of wealth such as inheritance, when the latter's normal earning does not commensurate with the proposed product purchased.

3.2.2 These measures should be designed in order to detect incorrect and/or incomplete information provided by policyholders in their application for insurance cover as well as incompatibility of the policyholder characteristics with the insured event and give due consideration to policyholder fraud indicators.

3.2.3 The insurer should also incorporate in its claims assessment procedures, clear requirements on what claims assessors should do to mitigate the risk of claims fraud, for example:

- checks against indicators for claims fraud;
- checks against internal database or other sources for confirmed or potential fraudsters; and
- interviewing claimants and conducting special investigations for suspicious cases.

3.2.4 The insurer should ensure that it possesses the relevant expertise, for example, by enlisting the services of fraud experts, when assessing claims. In addition, the authority limits assigned to claims assessors should commensurate with their experience and competency. The insurer should also consider the quality and reputation of any other third parties when placing reliance on material information provided by these parties. For this purpose, consideration should be given only to trusted or accredited third parties whose performance and practices have been or could be verified by the insurer.

3.2.5 To deter fraud, an insurer should inform policyholders that certain actions, such as knowingly providing false or misleading information to the insurer, submitting inflated or fictitious claims, etc could tantamount to committing fraud against the insurer and this could result in the loss of benefits or other consequences to the policyholders. It should also highlight to policyholders their contractual duties to the insurer when a policy is purchased or a claim is made.

Intermediary Fraud

3.2.6 An insurer should adopt adequate measures to ensure that the intermediaries it deals with meet fit and proper standards. It should establish an internal assessment framework for the appointment of its intermediaries, taking into account the principles encompassed in the “Guidelines on Fit and Proper Criteria (MCG-G01)”[2].

3.2.7 In assessing the fit and proper standards of its agents, the insurer should conduct adequate background checks on the agents including a search for any adverse records in reliable databases, such as the Agents Registration and Continuous Professional Development Management (“ARCM”) database for general agents. In addition, the insurer should conduct industry reference checks with the agents’ previous employers using the standard reference check letter adopted by industry and professional bodies in the financial services sector. The insurer should also develop a code of conduct for its agents, with appropriate penalties for non-adherence to the code or other misconduct by the agents.

3.2.8 An insurer which accepts business from financial advisory firms and insurance brokers should also ensure that the appointed firms’ performances are reviewed periodically to ensure compliance with the insurer’s fraud management controls.

[2] Issued by the Monetary Authority of Singapore in July 2005.

3.2.9 To minimise the risk of intermediary fraud, insurers should adopt the following measures where appropriate:

- ensure that policyholders' information such as mailing addresses are not altered without proper authorisation from or verification with the policyholders;

- send policies and documents as well as payments directly to policyholders rather than through intermediaries. If this is not possible, insurers should, at a minimum, send a separate notification to the policyholders if policies and documents as well as payments are dispatched via the intermediaries;

- prohibit intermediaries from accepting premium payments in cash (if this is unavoidable, receipts should be issued by the intermediary);

- strongly encourage policyholders to make all cheques payable to the insurer only and take additional precautionary measures such as indicating the policy number (for renewal policies) or the proposed policyholder's name and NRIC number (for new policies) on the back of the cheques;

- enhance the monitoring of an intermediary's own insurance policies and those of his immediate family members when there are grounds for suspicion;

- avoid issuing cheques in favour of parties other than beneficiaries of the insurance policies. Should the insurer decide to accommodate a policyholder's request to issue cheques made out in favour of a third party, the insurer should ensure that it has exercised due care to authenticate the authorisation given by the policyholder to issue the third party cheque; and

- enhance monitoring of cheques received through an intermediary that are issued by third parties who are unrelated to the intermediary to pay for policies owned by the intermediary or his immediate family members when there are grounds for suspicion.

3.3 RISK MONITORING AND REVIEW

3.3.1 An insurer should establish and maintain an incident database, which contains the names of staff or their immediate family members, policyholders, claimants or other relevant parties who have been convicted of fraud or have attempted to defraud the insurer.

3.3.2 It should also monitor the performance and trend of business brought in by the intermediaries in relation to the insurer's products with a view to detecting any indication of intermediary fraud. For example, should the actual level and pattern of business accepted by the intermediary differ significantly from the intermediary's track record and projections, this may warrant verifying whether there are legitimate reasons for the disparity.

3.3.3 The insurer should also conduct regular checks to ensure compliance with its policies and procedures in respect of its management of insurance fraud risk. For example, the checks should include verification that whenever fraud risk indicators are triggered, they are properly and consistently dealt with and adequately documented.

3.3.4 Senior management should ensure that proper and effective reporting systems are in place to satisfy all requirements of the Board with respect to reporting frequency, level of detail, usefulness of information and recommendations to address fraud risk. It is also the responsibility of the senior management to alert the Board promptly in the event that they become aware of or suspect that a fraud that may have a significant adverse impact on the insurer has occurred.