

INTERNATIONAL ASSOCIATION OF INSURANCE SUPERVISORS



GUIDANCE PAPER ON PREVENTING, DETECTING AND REMEDYING FRAUD IN INSURANCE

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1. Introduction

Risk and impact of fraud in insurance

1. Fraud poses a serious risk to all financial sectors. In the insurance sector, both insurers and policyholders bear the costs. Losses caused by fraudulent activities affect insurers' profits and potentially their financial soundness. To compensate, insurers raise premiums and this results in higher costs for policyholders. Fraud may also reduce consumer and shareholder confidence. It can affect the reputation of individual insurers, the insurance sector and, potentially, economic stability more broadly.

2. The increasing integration of financial markets and the growing number of international active insurers make fraud and its potential global implications an important issue to address at the international level. Therefore, fraud is a high priority for the IAIS.

3. The IAIS wants to ensure that insurers understand and take steps to minimise their vulnerability to fraud. Accordingly, this guidance paper has been developed to help insurance supervisors (hereinafter also referred to as "supervisors") and the insurance sector prevent and detect cases of fraud.

Definition of fraud

4. In this paper, fraud in insurance (hereinafter referred to as fraud) is defined as: an act or omission intended to gain dishonest or unlawful advantage for a party committing the fraud (hereinafter referred to as the fraudster) or for other 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 a financial decision, transaction or perception of the insurer's status
- abusing responsibility, a position of trust or a fiduciary relationship.

Types of fraud covered by this paper

5. Fraud comes in all shapes and sizes. It may be a simple act involving one person or it may be complex operation involving a large number of people from within and outside the insurer. This guidance paper deals with the following types of fraud:

- (a) **Internal fraud** – Fraud against the insurer by a director of the board, a manager or member of staff¹ on his/her own or in collusion with others who are either internal or external to the insurer.
- (b) **Policyholder fraud and claims fraud** – Fraud against the insurer in the purchase and/or execution of an insurance product by one person or people in collusion by obtaining wrongful coverage or payment.
- (c) **Intermediary fraud** – Fraud by intermediaries against the insurer or policyholders.

6. There are other types of fraud that affect insurers, but are not covered in this paper, such as:

¹ Regardless if the member of staff is employed on a permanent or temporary basis.

- fraud committed by contractors or suppliers that do not play a role in the settlement of insurance claims
- fraud by misrepresentation of insurance cover to attract investors, obtain favourable loans or authorisations or other types of favourable decisions from public authorities.

Objective of this guidance paper

7. This paper provides guidance so that the potential risk of fraud can be identified and reduced. Insurers should assess their own vulnerability and implement effective and efficient policies, procedures and controls to address the risk of fraud. Supervisors should be able to form an opinion of the internal control system of insurers and to select the most appropriate remedial action where the internal control system is weak. In some cases – for example, serious management fraud – intervention or action might be necessary with respect to the individual fraudster.

8. Insurance supervisors should consider the guidance contained within this paper, and determine how best to apply the guidance in the context of its own insurance industry.

Application of this guidance paper

9. This guidance paper applies to insurers (including reinsurers) and insurance intermediaries. In this paper reference to insurers should be read to include intermediaries. Insurers should ensure that their anti-fraud policies, procedures and controls apply to all their branches, including those located abroad. Insurers should therefore adopt a risk-based approach when addressing fraud on the basis of the fraud risk management required in section 2.3. This should be borne in mind when applying the guidance in this paper.

10. This guidance paper also applies to supervisors. Supervisors should require insurers within their jurisdiction to have effective anti-fraud policies, procedures and controls in place. In applying this guidance, supervisors should be sensitive to the risk profile of the insurer and take into account the size, nature and complexity of its business.

11. Reinsurers should apply this guidance paper – including sections 1, 2 and 6 – on a risk sensitive basis (for example, depending on the risk profile and the size, nature and complexity of their business). Reinsurers should apply section 3 on internal fraud in its entirety and, where they use intermediaries, section 5 as much as possible. With respect to section 4 on policyholder fraud and claims fraud, reinsurers should take into account policies, procedures and controls to manage fraud risk that their ceding insurers have in place as part of the reinsurer's own risk management.

12. 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. Staff of the ceding insurer may be colluding with third parties in a scheme intended to defraud the reinsurer – for example, scheming with policyholders, they could add costs not related to the claims recovery.

Relevant IAIS principles, standards and guidance

13. This paper contains guidance supporting a number of the IAIS Insurance core principles (ICP) and specifically addresses ICP 27².

² See Appendix A.

14. Other relevant ICPs are:
- *Principle 5: Supervisory cooperation and information sharing*
 - *Principle 7: Suitability of persons*
 - *Principle 9: Corporate governance*
 - *Principle 10: Internal control*
 - *Principle 13: On-site inspection*
 - *Principle 24: Intermediaries*
 - *Principle 28: Anti-money laundering, combating the financing of terrorism.*
15. Related IAIS standards and guidance papers are:
- *Standard No. 6: Exchange of information*
 - *Standard No. 23: Supervision of reinsurers*
 - *Standard No. 10: Fit and proper requirements and assessment for insurers*
 - *Guidance No. 2: Model memorandum of understanding to facilitate the exchange of information between financial supervisors*
 - *Guidance No. 5: Anti-money laundering and combating the financing of terrorism*
 - *Guidance No. 10: Combating the misuse of insurers for illicit purposes*
 - *Guidance No. 11: Risk transfer, disclosure and analysis of finite reinsurance.*

Structure of guidance paper

16. Following this introductory section,
- Section 2 describes the characteristics of fraud and provides general profiles of fraudsters. It emphasises the need for insurers to deal with fraud as part of their risk management and internal control systems.
 - Sections 3, 4 and 5 address each of the three main categories of fraud to which insurers are exposed and set out procedures and controls that can be used to prevent and to detect them. These sections form in more detail a risk-based approach to these types of fraud in insurance.
 - Section 6 discusses how insurers can also address fraud by training staff, reporting occurrences and exchanging of information with other insurers and other financial institutions.
 - Section 7 addresses the responsibilities, duties and resources required of supervisors, as well as methods to assess and monitor compliance with fraud risk management of insurers. It stresses the importance of supervisors cooperating with other relevant authorities.
 - Appendix A contains the text of ICP 27. Appendices B to F set out fraud indicators and case studies. Appendix G makes a summary of terms for the IAIS Glossary of Terms.

2. Fraud risk in insurance

2.1. Fraud triangle

17. There are three basic components that contribute to the occurrence of fraud, namely:

- (a) motive/incentive
- (b) opportunity
- (c) rationalisation.

These basic components are often known as the fraud triangle.

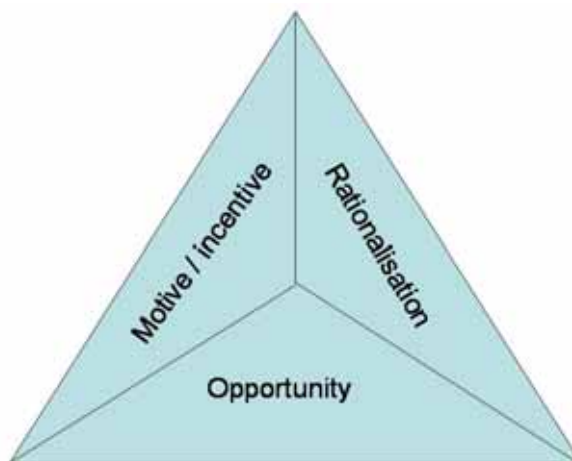


Figure: Fraud triangle

18. People commit fraud for a variety of reasons. They could, for example, have financial problems or be under pressure to meet unrealistic business objectives. Insurers should be aware of the potential for these conditions to exist and look for signs of possible fraud.

19. Fraudsters need to have the opportunity to commit fraud. They are more likely to act when they think the likelihood of detection is small. Therefore insurers should have proper policies, procedures and controls to both prevent fraud from taking place and, if fraud does take place, to detect it.

20. Rationalisation is the mental process of justifying the fraud. For example, people may commit fraud because they:

- are dissatisfied with an insurer as an employer
- perceive an entitlement to compensation because of premiums paid
- take an “every one does it” attitude
- are copying the behaviour of others in the insurer, such as management or the board of directors.

Also, public attitude regarding fraud in insurance does not deter fraud as many people see such fraud as a victimless crime.

21. The possibility of fraud is significantly reduced if the proper checks and balances exist. In designing appropriate policies, procedures and controls, insurers should be aware that their vulnerability to fraud is influenced by the business environment affecting the insurers operations, as well as by the integrity and personal conditions of the directors of the board, managers and staff.

2.2. Profiles of insurance fraudsters

22. There are two general profiles of fraudsters:

- (a) The “opportunity” fraudster: an opportunity fraudster is normally a law-abiding person who sees an opportunity to commit fraud. For example, this type of fraudster might imagine that insurers have limitless funds and might find it acceptable to make up claims in order to recover the costs of premiums paid in previous years when there have been no claims. With regard to internal fraud the fraudster might, for example, falsify expenses or the financial accounts of an insurer for his/her benefit.
- (b) The “professional” fraudster: a professional fraudster earns or complements his/her income by committing fraud. He or she may continue committing fraud until detected and may target a number of insurers. An extension of the professional fraudster profile is organised crime involving a group of persons capable of committing complex and extensive frauds. The fraudulently obtained funds may be used to finance other criminal acts.

2.3 Fraud risk management by insurers

23. Insurers should be constantly vigilant in deterring fraudsters. As part of their corporate governance the boards of directors of insurers should recognise and understand the risks of fraud to their organisation, including the potential types and impact of fraud. By understanding the risks of internal, policyholder, claims and intermediary fraud, insurers can decide which procedures and controls can be implemented effectively and efficiently to manage these risks.

24. Fraud risk management should be a component of every insurer’s risk management framework. Responsibility for fraud risk should be allocated at the board of directors and at management level.

25. Insurers should address fraud risk when establishing their mission, strategy and business objectives. The overall policy should be consistently implemented in departmental objectives. It should be reflected in the relevant operational procedures and controls, for example, for:

- developing products
- accepting clients
- hiring and firing of management and staff
- outsourcing
- handling claims.

26. For this purpose it is essential that an insurer should:

- establish and maintain a sound control environment through policies, procedures and controls. Insurers should require high standards of integrity in its board of directors, management and staff as part of their business values and a proper organisational culture.
- demonstrate a proper support by the board of directors and management (“tone at the top”), and overall communication of these values throughout their entire organisation.
- set realistic business objectives and targets and allocate sufficient resources for the board of directors, management and staff to meet them.

- organise and collect management information with respect to fraud in insurance, making it available in a timely manner for the board of directors and management to monitor developments and take appropriate action. This information should be used to periodically evaluate the effectiveness of policies, procedures and controls and make changes where necessary.
- establish and maintain an adequate and independent audit function to test risk management, procedures and controls.

27. The extent and specific form of policies, procedures and controls needed to prevent and detect fraud should be determined following a risk analysis. Relevant factors to consider include:

- size of the insurer
- group, responsibility and organisational structure
- products and services offered, and
- market conditions.

28. Fraud risk can be impacted by the insurer's method of distribution, for example, direct writing or use of tied agents or independent brokers. The amount of contact with the client, involvement of the insurer's staff and reliance on third parties can differ depending on the distribution method used and this will influence the nature and size of the risk of fraud. Special policies, procedures and controls may be needed when new technologies, such as the internet, are used to distribute products.

29. If warranted by their risk profile and by the size, nature and complexity of their business, insurers should consider introducing a separate fraud management function. This function would be responsible for the design of, and compliance with, the insurer's anti-fraud policies, procedures and controls, as well as any fraud investigations. It could maintain the insurer's fraud statistics and related management information. In addition, this function could coordinate the information exchange with other insurers and financial institutions and with third parties, such as law enforcement authorities. If established, the fraud management function would need to:

- have the requisite authority
- have sufficient resources
- be able to raise issues directly with the board of directors or board risk or audit committee, and
- be able to maintain confidentiality.

30. As part of their fraud risk management, insurers should have a set of measures and procedures to be able to respond adequately and, if necessary in emergency situations, quickly to (suspected) cases of fraud. These measures and procedures would include possible fraud investigation.

31. Fraud investigations require a variety of possible areas of expertise (for example: legal, forensic, IT, auditing and medical expertise). Insurers should ensure that they have the relevant expertise either in-house or by outsourcing fraud investigations to appropriate third parties, if the quality of fraud investigations and the confidentiality of information are not compromised by the outsourcing.

32. The board of directors and management should ensure that the nature and frequency of reporting, as well as the time allocated for considering fraud matters, is sufficient since they are responsible for establishing and implementing the requisite policies, procedures and controls. Information about fraud, such as trends and profiles of fraudsters,

should be shared and known throughout the insurer. Possible indicators of fraud (or red flags) can therefore be identified early by putting together different pieces of information.

33. Insurers should regularly review their anti-fraud policies, procedures and controls taking into account of the dynamic nature of fraud. When an insurer has been exposed to fraud, it should use the incident to identify "lessons learned" and adjust its policies, procedures or controls to minimise the risk of the fraud recurring.

3. Internal fraud

3.1. Internal fraud risk

34. As part of their management of operational risk, insurers should consider the effect on staff morale as well as the potential for financial losses resulting from internal fraud. Internal fraud also poses a reputational risk to insurers. Severe cases could precipitate economic ruin of insurers (see Appendix B – Examples and cases of (alleged) internal fraud in insurance).

35. Factors influencing an insurer's vulnerability to internal fraud include:

- its complexity – internal fraud is more likely to occur in insurers with a complex organisational structure, where there is increasing compartmentalisation of responsibilities or lack of identification with the insurer.
- its speed of innovation – the speed of modern commerce, product development and computerisation, promote opportunities for fraud.
- its remuneration and promotion policies – the incentive to commit fraud may be greater if an employee's pay and status depend on meeting certain targets.
- the economic climate and business situation – phases of instability within an insurer such as mergers and acquisitions or takeover bids may provide unexpected opportunities for fraud. Fraud is more likely to occur when an insurer's control systems and environment are not sufficiently robust.

Generally, internal fraud occurs on all levels, including at the level of the board of directors and management. The higher the level at which the fraud is committed the higher the likely financial loss and reputational damage.

36. Employees pilfering cash or insurer's resources – such as equipment, stock, or information – represent the most conventional fraudulent behaviour. However, corrupt employees also engage in far more costly schemes. These include bribery and kickbacks. A bribe usually "buys" something, for example, the influence of the recipient who makes the business decision. Although not as common as other types of fraud, commercial bribery schemes are usually very costly and involve collusion between employees and third parties. Typically, these schemes involve receiving kickbacks or commissions from a supplier as a reward for awarding the contract. This type of fraud is particularly difficult to detect, since the kickback is paid directly from the supplier to the employee and does not go "through the books" of the insurer. Such corrupt practices often escape detection, unless exposed by other employees, vendors or other third parties.

37. Typical warning signs for internal fraud are:

- managers or members of staff working late, who are reluctant to take vacations or who seem to be under permanent stress
- directors of the board, managers or members of staff resigning unexpectedly

- marked personality changes of directors of the board, managers or members of staff
- unexplained wealth of or living beyond apparent means by directors of the board, managers or members of staff
- sudden change of lifestyle of directors of the board, managers or members of staff
- key managers or members of staff having too much control and/or authority without oversight or audit by another person, or who resist or object to (independent) review of their performance
- directors of the board, managers or members of staff with external business interests and/or cosy relationships with third parties giving rise to conflicts of interest. For example, a disproportionate amount of business or other forms of “support” may be granted to third parties who are not at arm’s length from managers or members of staff
- customer complaints
- missing statements and unrecognised transactions
- rising costs with no explanation.

38. The existence of these warning signs or indicators does not mean that internal fraud has occurred or will occur. Nevertheless, insurers should be looking out for these warning signs or indicators, particularly when more than one occurs. Appendix C – Potential internal fraud indicators – red flags presents an extended list of potential risk indicators.

3.2. Internal fraud prevention

39. Preventive measures are essential for controlling the risk of internal fraud. They also help the insurer avoid the negative effects of adverse publicity and supervisory attention or intervention, if a serious case of internal fraud is detected.

40. Insurers should identify both the processes of their organisation that are vulnerable to internal fraud and the consequent individual internal fraud risks.

41. Preventive policies, procedures and controls include (among other things):

- creating a culture and atmosphere which place value on the integrity of directors of the board, management and staff, which foster their identification with the insurer, and which put value on staff that call colleagues to account about matters of misconduct
- issuing an office manual and internal guidelines on ethical behaviour for management and staff
- maintaining adequate supervision of management and staff
- performing pre-employment and in-employment screening of permanent or temporary management and staff
- establishing clear responsibilities in documented job descriptions or role statements
- requiring periodical job rotation and mandatory vacations for management and staff in fraud sensitive positions
- eliminating potential conflicts of interest between the insurer, board of directors, management and staff

- separating or dividing any function that may cause or be susceptible to conflicts of interest
- observing the four eyes principle (checks by a second person)
- establishing efficient physical and procedural safeguards over the use, handling and availability of cash, other assets and transactions as well as of information systems
- arranging for cash and money flows to be dealt with by more than one person
- establishing clear reporting lines and communication procedures
- establishing internal complaints procedures for disgruntled management and staff
- establishing a transparent and consistent policy in dealing with internal fraud by board of directors, management and staff, including policy on notification to the relevant law enforcement agency
- establishing a clear dismissal policy for internal fraud cases in order to deter other potential perpetrators.

42. Insurers should raise awareness of the potential for internal fraud within their organisation. For example, the board of directors, management and staff should be provided with guidance on potential internal fraud indicators and training on preventing, detecting and remedying internal fraud (see section 6.1 on training).

43. Fit and proper standards should be established for members of the board of directors, management and staff that are appropriate for their position and responsibilities. Equivalent standards should be set for third parties hired by insurers to perform activities in high risk areas.

44. The initial and on-going assessment of the fitness and propriety of management and staff should include the verification of identity, personal information and background.

45. Personnel records should be complete and contain all information on the recruitment of the directors of the board, managers and staff. Records should be retained for an adequate period of time after the person in question has left the insurer.

46. During recruitment, insurers should be aware that applicants could provide false information, such as false employment history, false references and certificates or false identity.

3.3. Internal fraud detection

47. Internal fraud detection supplements internal fraud prevention. It demonstrates the effectiveness of preventive policies, procedures and controls. It should be borne in mind that the ways of committing fraud are limited only by the imagination of the individual(s) – this “human factor” makes the detection of internal fraud particularly difficult and therefore makes prevention of major importance.

48. Internal audits are a successful tool for detecting internal fraud. Therefore, insurers should carry out risk-based internal audits at appropriate intervals. In order to be effective audit staff needs timely access to information and technological tools to audit computerised systems and files.

49. An internal audit function should be independent from day to day activities and accountable to the board of directors or an equivalent body. If appropriate, and while still retaining accountability for the work undertaken, the insurer could assign the audit function to an independent external organisation. Internal audits should be applied to the board of

directors and all management and staff levels. They should include all the insurer's business lines and processes.

50. Insurers should encourage management and staff to report irregularities. They can increase the chance of detecting fraudsters by establishing confidential reporting mechanisms (see section 6.2). Confidential reporting mechanisms demonstrate to staff that the insurer is intolerant of fraud.

51. Some insurers have a policy on disclosure of information on potential fraud or other unlawful behaviour (for example, whistle blowing). The exposure and reporting of fraud and abuse committed by a director of the board, manager or member of staff can be a valuable source of information for addressing internal fraud.

52. Exit interviews when a director of the board, manager or member of staff leaves the insurer can provide useful information for countering fraud.

4. Policyholder fraud and claims fraud

4.1. Policyholder fraud and claims fraud risk

53. Policyholder fraud and claims fraud can be committed by policyholders at inception of the insurance contract, during the insurance contract or when claiming payment or compensation. Claims fraud can also be committed by third parties involved in the settlement of a claim. For example, medical practitioners could claim for medical services which have not been provided or engineers could inflate the costs of repairs.

54. The policyholder may deliberately withhold, or provide incorrect, background and other information, for example, the refusal of coverage by other insurers or claims background. This is a serious risk for insurers, who might not have provided cover or who would have provided cover under different conditions (higher premium or higher retention) if they knew this information.

55. Claims fraud could have any of the following features (See Appendix D –Cases of (alleged) policyholder fraud and claim fraud in insurance):

- reporting and claiming of fictitious damage or loss
- exaggerating damages or loss covered by the insurance
- misrepresenting a fact to create the appearance of an incident being covered by the policy
- misrepresentation of the damaged party by an impostor
- staging the occurrence of incidents causing damage or loss covered under the policy.

56. Claims fraud could occur in combination with other types of fraud, such as identity fraud. There have, for example, been cases of medical treatment being given to people using the identity of others who are insured against the expenses of this medical treatment.

57. Insurers should deal with policyholder fraud and claims fraud risk as part of the operational risk of their business. In establishing the most appropriate policies, procedures and controls, insurers assess the benefits and costs of fraud prevention and detection, but need to:

- understand that while ease and speed of acceptance and claims settlement is desirable from a marketing perspective, it could result in a higher fraud risk. This risk may be mitigated by adequate anti-fraud policies, procedures and controls.

- consider their moral and ethical responsibility to prevent fraud and promote the integrity of the insurance industry
- recognise that fraud affects their reputation – consumers may assume fraud is related to other criminal activities and expect that a high fraud frequency will lead to higher premiums or possible failure to pay claims.
- identify, prevent and detect types of fraud that should receive specific attention because they threaten the interests of policyholders or other third parties, for example, fraud by organised criminal gangs committing complex and extensive frauds and fraud for which other criminal action is needed, such as staged car accidents.³

4.2. Policyholder fraud and claims fraud prevention

58. Policyholder fraud and claims fraud prevention starts with adequate product development (product proofing) by insurers. When designing a new insurance product, insurers need to be aware of risk enhancing factors. For example, policyholders in financial difficulties may be encouraged to stage the theft of a car or to commit arson to their property if the terms of the insurance contract provide for compensation on the basis of replacement value instead of current value or “new for old”. This could be a consideration when deciding on the contractual terms of the policy. Insurers may also consider offering policies with claims replacement services. In these policies the loss is compensated by a replacement in kind instead of compensation in cash.

This is not to say that these terms should not be used, but insurers should be aware that they could increase the risk of fraud and should ensure appropriate controls to mitigate these risks are in place.

59. Insurers should assess the inherent fraud risk of their existing insurance products. In making their assessment insurers should involve those with relevant expertise, for example, fraud experts or claim settlers.

60. Insurers should establish an adequate client acceptance policy and consider for that purpose the following elements:

- Part of the client acceptance policy should include the categorisation of expected product-client combinations.
- For each combination it should be clear whether and under which conditions a client can be accepted and which measures insurers should take to prevent or detect fraud.
- The categorisation should be evaluated periodically. Part of this evaluation should include a comparison of detected fraud rates with expected fraud rates.

61. Insurers should establish adequate client acceptance procedures and consider for that purpose the following elements:

- Unexpected product-client combinations should receive special attention.
- Client should be identified and the identity verified.
- Approaches used for client acceptance include:
 - using professional judgement based on experience

³ Often the fraudulently obtained money is used to finance other criminal acts.

- checking red flag lists (see the list of “Potential policyholders and claims fraud indicators – red flags” in Appendix E)
- conducting peer reviews
- checking internal and/or external databases.

62. The procedures should include clear criteria that indicate which approaches should be used for each product-client combination. The effectiveness and efficiency of the client acceptance process and the success rate of fraud prevention may be increased by using automated means of checking client information against internal and/or external databases and against lists of red flags. This should be considered when deciding the extent of automation in the client acceptance processes.

63. Some insurers delegate their client verification and risk assessment processes to an intermediary. Nevertheless, they retain ultimate responsibility. As a result:

- Insurers should establish and implement a policy on client identification and verification and risk assessment by intermediaries.
- The terms of business with intermediaries should be consistent with this policy.
- Insurers should monitor compliance by the intermediaries with these terms of business.
- Insurers should have access to the identification and verification information concerning the risk assessment of clients.

64. Insurers should draw the attention of their policyholders and/or beneficiaries to their duties when taking out insurance or reporting a loss. Examples include:

- minimising losses
- reporting claims in a timely manner
- co-operating in the investigation following a claim by providing insurers with all relevant information and, in particular, copies of official documents regarding the damage (accident, loss, etc.) in a timely manner
- authorising the insurers to carry out necessary inspections and to assess the extent of the damage prior to any repairs or replacement.

65. Insurers should inform both potential clients and existing clients about their anti-fraud policies.

66. Insurers should consider including in insurance contracts and in other relevant documents (for example, the claims form) provisions which make the policyholder, claimant and beneficiary aware of the consequences of submitting a false statement or incomplete statement. For example, they could be liable to prosecution or refused cover by the insurers. Where information is obtained orally (for example: in face to face meetings or telephone conversations) policyholders, claimants and/or beneficiaries should similarly be advised of the consequences of making a false or incomplete statement.

67. Insurers should consider the quality and reputation of third parties – such as medical practitioners, service engineers and contractors – used for compensation, restoration or repair of the loss or damage. Consideration should be given to using trusted third parties whose performance and business practices can be checked by the insurers.

4.3. Policyholder fraud and claims fraud detection

68. Insurers should be aware of the risk that the client might provide incorrect or incomplete information to obtain a lower premium or a higher coverage. Adequate policies,

procedures and controls appropriate to the fraud risk profile of the product-client combination should be developed and implemented to detect incorrect and/or incomplete information when handling applications from new clients or from existing clients for new products. These policies, procedures and controls may include an assessment of the compatibility of the characteristics of the policyholder and the insured events.

69. Claim assessment procedures should be established by insurers. When handling claims, insurers should make an assessment of the fraud risk of the claim.

70. The procedures and controls for claim assessment may include :

- using professional judgement based on experience
- checking red flag lists
- conducting peer reviews
- checking internal and/or external databases or other sources
- using IT tools, such as voice stress analysis, data mining, neural networks and tools to verify the authenticity of documents
- interviewing claimants
- conducting special investigations.

71. The procedures and controls should include clear criteria that help the claim assessor to ascertain which assessment method should be used. The effectiveness and efficiency of the claim assessment process and the success rate of fraud detection may be increased by using automated means of checking claims against internal and/or external databases and against lists of red flags. Insurers should consider this when deciding on the extent of automation in the claim assessment processes.

72. Insurers should consider that operational targets for efficiency of the client acceptance and the claim assessment processes may hamper fraud detection. Preferably, operational targets should be combined with targets for fraud detection.

73. Insurers that use claims adjusters or intermediaries for claim assessment will need to ascertain their competence and qualifications. Insurers may decide to limit the scope of action of claims adjusters and intermediaries (for example, by setting ceilings on the number or size of claims they can handle and/or the type of claims to be handled). Also, the fee structure for claims handling should not be set up in such a way that it diminishes the critical stance of the claims adjuster towards the (size of the) claim or loss.

74. Insurers should establish and maintain their own incident database. The database would contain the names of (former) policyholders, claimants, beneficiaries or third parties who could potentially attempt to defraud the insurers.

5. Intermediary fraud

5.1 Intermediary fraud risk

75. Insurance intermediaries – independent or otherwise – are important for distribution, underwriting and claims settlement. It is possible for intermediaries to keep records of insurers' clients. Intermediaries are therefore involved in some of the most important processes and transactions of insurers and are crucial in insurers' operational and fraud risk management.

76. Intermediaries sit in a position of trust between the purchasers of insurance and insurers. Where trust forms a basic element of any transaction, there is the danger of this trust being abused.

- Examples of involvement of intermediaries in fraud include (see Appendix F – Specific cases and examples of (alleged) intermediary fraud in insurance):
- withholding of premiums collected from a policyholder until a claim is reported
- insuring non-existent policyholders while paying a first premium, collecting commission and annulling the insurance by ceasing further premium payments
- colluding with policyholders to commit claims fraud or other types of fraud, for example, backdating transactions by providing false information to the insurer.

77. Typical warning signs⁴ for intermediary fraud include:

- the intermediary asks for payment of commission immediately or for payment of commission in advance
- the policyholder/insured lives outside the region where the intermediary operates
- an intermediary has a small portfolio but high insured amounts
- premiums received and commissions paid are above or below the industry norm for the type of policy
- the policyholder is asked to make payments via the intermediary where this is an unusual business practice
- the insured and the intermediary are represented by the same person
- there is a personal or other close relationship between the client and the intermediary
- there are unexpected developments or results such as:
 - a high claim ratio
 - an increase of production that is exceptional or without apparent reason
 - a significant number of policy substitutions with complete commission
 - a high level of early cancellations or surrenders
 - a high number of unsettled claims
- the portfolio of the intermediary has (relatively) a lot of insurance policies
 - of which the commission is higher than the first premium
 - with an arrear of premium payments
 - with a payment shortly after inception (particularly life insurance)
 - with a high amount of claims fraud
 - with a disproportionate number of high risk insured persons, for example, elderly people
- the intermediary often changes address or name

⁴ The existence of these warning signs or indicators does not mean that intermediary fraud has occurred or will occur. Nevertheless, insurers should be looking out for these warning signs or indicators, particularly when more than one occurs.

- there are frequent changes in control or ownership of the intermediary
- there are a number of complaints or regulatory inquiries
- the intermediary is in financial distress
- the intermediary is involved in unauthorised third party business
- the intermediary appears to be churning policies
- the intermediary insists on using certain loss adjusters and/or contractors for repairs.

5.2 Intermediary fraud prevention and detection

78. Insurers should take all reasonable steps to confirm that the intermediaries they use meet fit and proper standards and have adequate safeguards for the sound conduct of business. In order to achieve this effectively, insurers should only grant terms of business to regulated intermediaries and should consider:

- having in place a documented policy and procedure for the appointment of new intermediaries
- having an application form and terms of business agreement that have to be completed and signed by the intermediaries
- ensuring the application form requires applicants to disclose relevant facts about themselves
- checking the financial soundness of the applicant and checking references
- having an effective sanction policy in case of non-compliance by the intermediary.

79. The terms of business agreements could require the applicant intermediary to confirm:

- that the introduction of business to insurers pursuant to the agreement does not breach any other legal obligation or the rules of any competent authority in any relevant jurisdiction
- that at all times during the term of the agreement, the intermediary will maintain all obligatory licences, authorisations or registrations and comply with all applicable laws and regulations of the jurisdictions where it operates
- its compliance with the insurer's anti-fraud policies, procedures and controls.

80. In order to reduce the potential for commission fraud, insurers should consider:

- not paying commission before the first premium has been paid
- not paying more commission than a certain percentage of premiums paid
- keeping part of the earned commission in a temporary deposit when dealing with new, unknown intermediaries
- making a clear distinction between the funding of intermediaries and the payment of commission.

81. Insurers should have in place documented policies, procedures and controls to monitor the performance and business of the intermediaries. These policies, procedures and controls should be made known to the intermediaries. Elements to consider could include, but are not limited to:

- quality of business, including the soundness and ethics of the intermediaries' business conduct and integrity of their boards of directors, management and staff
- anticipated and actual levels and patterns of business
- the warning signs mentioned in section 5.1.

82. Possible additional procedures and controls to prevent intermediary fraud for insurers to consider are to:

- send policies and renewal documents directly to the policyholders rather than via the intermediaries – intermediaries can be provided with copies
- instruct intermediaries not to accept premium payments in cash
- make all premium cheques payable to the insurer and not permit the intermediary to negotiate cheques payable to the insurer
- ensure that intermediaries operating client accounts have sufficient safeguards in place, with controls over who can operate the bank authorisations and with appropriate reporting lines
- have staff of the insurer or its auditor periodically audit the insurance business going through the intermediary.

6. Supporting organisational measures and procedures

6.1 Training of boards of directors, management and staff

83. Insurers should organise initial and ongoing training on fraud matters for their boards of directors, management and staff. The type of training should correspond with the business process in which the person is engaged. Also, it should reflect the risks he or she may encounter in fulfilling his or her responsibilities.

84. At a minimum the board of directors, management and staff should receive a general explanation of the insurer's anti-fraud policies, procedures and controls. This includes internal rules – for example, a code of conduct for the board of directors, management and staff. They should be made aware of the need to report suspicions of fraud.

85. Some directors of the board, managers and members of staff need, due to their assigned work, more specific training – for example, on relevant laws, anti-fraud policies, procedures and controls, fraud methods, trends and indicators, detection methods, and internal reporting procedures. In particular, fraud training should be provided to those who deal with:

- new business and the acceptance – either directly or via intermediaries – of new policyholders
- the collection of premiums
- settlements and payments of claims
- business with intermediaries
- recruitment of staff
- legal affairs
- internal auditing
- fraud risk management

- fraud investigations (for example, interview techniques and use of relevant IT).

6.2 Reporting suspicions of fraud

86. Insurers should have internal procedures requiring directors of the board, managers and members of staff to report suspicions of fraud to a designated person⁵. Individuals reporting their suspicions of fraud in good faith should have adequate legal protection. In particular it is recommended that they not be held liable for disclosing confidential information.

87. Insurers should have a policy on keeping records of suspicions of fraud and fraud cases. This policy could provide for:

- criteria for the cases for which records should be kept
- the type of the information that should be recorded
- the period for which information should be kept
- access to the information, and
- safeguards for retaining the information securely.

88. Internal, policyholder, claims and intermediary fraud generate illegal proceeds. If an insurer suspects, or has reasonable grounds to suspect that the proceeds of the fraud are being laundered or are related to terrorist financing, its compliance officer⁶ should report the suspicions promptly to the Financial Intelligence Unit (FIU).

89. Insurers should have clear policies for reporting suspicions of fraud to law enforcement agencies. How insurers choose to proceed will depend on the legal system and other characteristics of their jurisdiction, including any legal obligation to report criminal offences. It should be noted that a strict reporting policy by the insurer will contribute to countering fraud.

90. Insurers should communicate – internally and externally – their policies and procedures on reporting and sanctioning fraud.

91. Insurers should notify their supervisors of any fraud related matters which either require specific notification under the supervisor's regulations, or has been specifically requested by the supervisor. Insurers should at minimum report frauds with a (potentially) material impact on their financial position, business or reputation to their supervisors. Aggregate information about fraud and changes in fraud policies should be available to supervisors.

6.3 Information exchange between insurers and other financial institutions

92. Fraudsters may target different insurers simultaneously or consecutively. Therefore, insurers should share information about fraudsters with each other. This may be achieved, within the limits of the privacy law and the data protection law of the insurer's jurisdiction, by timely communication between them and setting up shared databases.

93. A shared database may contain information about internal fraudsters and fraudulent policyholders, claimants, beneficiaries, intermediaries and other third parties.

⁵ Depending on the type of fraud the designated person could be a director of the board, a (line) manager or a high level reporting officer, for example, a compliance officer or fraud risk manager.

⁶ In some jurisdictions the compliance officer is referred to as the money laundering reporting officer (MLRO).

94. Fraudsters may also target other financial institutions. Therefore, it is recommended that insurers, within the limits of the privacy law and the data protection law of the relevant jurisdictions, share information within the financial sector. This can be achieved by linking their shared database to databases operated by other financial institutions or setting up a shared database.

95. In addition to the exchange of specific information about fraudsters, insurers are recommended to share knowledge about fraud risk, trends, policy issues, prevention and detection. Cooperation with organisations involved with combating fraud in the insurance sector (such as organisations for chartered accountants, forensic auditors, claims adjusters, law enforcement agencies, supervisors and possibly consumer organisations) should be encouraged. This may include enhancing consumer/policyholder awareness on insurance fraud and its effects through education and media campaigns. Industry and trade associations can play an important role in this process.

7. Role of the supervisor

7.1 General

96. Countering fraud is in principle the concern of the individual insurers. Fraud on insurers is an issue for supervisors if the risk of fraud is not addressed adequately. Therefore, supervisors should pay appropriate attention as to whether insurers have adequate and effective policies, procedures and controls in place to prevent, detect and remedy fraud.

97. Supervisors should have adequate powers, including the authority to conduct on-site inspections, to monitor and ensure compliance by insurers with supervisory requirements to prevent, detect and remedy fraud. Supervisors should have powers to require the production of any documents and information from insurers that are relevant to monitoring such compliance, and to impose adequate administrative sanctions for failure to comply with such requirements.

98. Supervisors should have the powers and resources to enforce regulations and to communicate as appropriate with law enforcement authorities, as well as with other supervisors, to deter, detect, record, report and remedy fraud in insurance.

99. Supervisors should have adequate financial, human and technical resources to assess the insurance sector's ability to counter fraud. Supervisors should have in place policies and procedures to ensure their staff are of high integrity. They should have adequate and relevant training with respect to fraud legislation and fraud typologies and should be familiar with the techniques used to monitor compliance with anti-fraud standards.

100. Supervisors, in performing other functions, indirectly assist insurers in taking the necessary measures to prevent, detect and remedy fraud. By way of example, relevant duties set out in the Insurance core principles and methodology include:

- the assessment of insurers' standards of corporate governance and internal controls
- the approval of control and significant ownership of insurers and changes thereto
- the review of the suitability of significant owners, directors of the board and senior management (fit and proper testing).

101. Supervisors should form an opinion as to whether local legislation adequately addresses internal fraud, policyholder fraud, claims fraud and intermediary fraud. The legislation should contain offences and penalties for committing such fraud and for

prejudicing an investigation into fraud. It should also provide the ability for an appropriate domestic or international authority:

- to obtain documents and information, together with statements made by key individuals, for intelligence and investigation purposes, for disclosure to other appropriate authorities
- to restrain assets which represent, or are believed to represent, the proceeds of fraud
- to confiscate assets which are, or are believed to be, the proceeds of fraud.

102. There should be gateways for suggesting improvements in legislation to the appropriate legislative authorities.

7.2 Supervision of anti-fraud measures and fraud risk management

103. Supervisors should adopt a risk-based approach to supervising insurers' efforts at mitigating their fraud risk. This should be borne in mind when applying the guidance in this section.

104. Supervisors should monitor compliance by insurers with applicable anti-fraud regulations.

105. Supervisors should assess whether insurers have adequate fraud risk management systems in place which are reviewed regularly. Supervisors should be convinced on the basis of information provided by insurers that the latter are in control of their fraud risk and possible risks to their solvency or continuity caused by fraud. As a minimum supervisors should assess whether insurers:

- have adequate internal policies, procedures and controls in place to prevent, detect and remedy fraud
- have an adequate and independent internal audit function and periodically carry out fraud sensitive audits
- maintain a clear division of responsibilities between the board of directors and senior management, and pay attention to whether the level of competence of the directors of the board, management and staff is commensurate with their responsibilities and duties
- operate under high standards of integrity and whether the directors of the board, management and staff have the integrity and qualifications to fulfil their responsibilities at the stage of recruitment and beyond
- have allocated appropriate resources to deter, detect, record and, as required, promptly report fraud to the relevant authorities
- have clear and appropriate reporting lines for communication throughout the insurers and sufficient information flow to the board of directors
- maintain proper documentation and adequate records
- maintain initial and ongoing training for their directors of the board, managers and members of staff.

106. Supervisors should take account of the risk of fraud at each stage of the supervisory process, including the licensing stage.

107. When conducting on-site inspections, supervisors should be sensitive to fraud risk and check relevant documentation. For example, the supervisor may check, at random or on

a risk basis, internal reports on suspicions of fraud or actual fraud cases, and formal reports to the law enforcement authorities.

108. From a risk-based perspective supervisors should, if necessary, conduct examinations of claims management. This would take into account the following elements:

- access to client acceptance and claims data, and
- assessment of the quality of the client acceptance and the claims handling process.

109. Supervisors should take appropriate corrective measures or issue sanctions and, unless the insurer has addressed the matter, refer to the law enforcement authorities the cases where there is substantiated suspicion of a criminal offence involving the insurer.

7.3 Cooperation and information exchange

110. In accordance with IAIS ICP No. 5 and other relevant ICPs, supervisors should, subject to their competences, provide the widest possible range of cooperation with domestic and international supervisors across the financial sector. There should be clear and effective gateways, for example, by means of bilateral agreements such as Memoranda of Understanding, to facilitate the prompt and constructive exchange of information directly between supervisors, either spontaneously or upon request. Where possible, supervisors should be able to conduct enquiries and investigations on behalf of other supervisors.

111. Supervisors should also have effective mechanisms in place which enable them to cooperate and coordinate domestically concerning the development and implementation of legislation, policies and activities to deter, record, report and remedy fraud. Cooperation should not only include other supervisors but also policy makers, the FIU and law enforcement agencies. Subject to their competences supervisors should actively promote fraud awareness in the insurance sector. Such awareness will encourage the development of industry best practices to counter fraud encompassing anti-fraud legislation, policies and activities.

112. Supervisors should consider appointing a contact in their office for fraud issues. Supervisors should liaise with other national authorities to promote an efficient exchange of information on general trends and risks, as well as policy issues. Information on specific cases should be shared where it is relevant to a national authority concerned. Insurers should highlight issues of compliance with anti-fraud standards to the FIU and law enforcement authorities. The FIU and law enforcement authorities should provide them with feedback on reported cases.

113. Supervisors should promote the exchange of information between insurers on fraud and fraudsters including, as appropriate, through the use of databases. Supervisors should also cooperate with relevant industry and trade associations to encourage or maintain an industry-wide approach to countering fraud.

114. Whenever supervisors are informed of substantiated suspicious fraudulent activities which might affect the insurance industry as a whole, they should consider whether to convey warning information to insurers to the extent permitted by local laws and regulations.

115. In addition, supervisors may consider contributing to the following initiatives:

- the establishment of anti-fraud committees consisting of industry or trade organisations, law enforcement agencies, supervisors and possibly consumer organisations as a platform to address fraud in insurance – for example, by discussing trends, risks, policy issues, profiles and modus operandi

- the establishment of a fraud database on suspected and/or confirmed fraud attempts; insurers could be requested or required to submit information and statistics with respect to these attempts
- the enhancement of consumer/policyholder awareness on insurance fraud and its effects through effective education and media campaigns
- cooperation between organisations involved with combating fraud in the insurance sector, including organisations for chartered accountants, forensic auditors and claims adjusters.

Appendix A – IAIS Insurance core principle on fraud

ICP 27 Fraud

The supervisory authority requires that insurers and intermediaries take the necessary measures to prevent, detect and remedy insurance fraud.

Explanatory note

27.1. The supervisory authority has an important role to play in combating fraud in insurance in its jurisdiction. It communicates with other supervisors in addressing such fraud across jurisdictions.

27.2. Fraud can be perpetrated by any party involved in insurance, for example, insurers, insurers' managers and staff, intermediaries, accountants, auditors, consultants, claims adjusters as well as policyholders.

27.3. Most jurisdictions have legal provisions against fraud in insurance. In many jurisdictions, instances of fraud are criminal acts.

27.4. Fraud in insurance results in reputational as well as financial damage and social and economic costs. That is why the supervisory authority requires that insurers and intermediaries address it effectively.

Essential criteria

- (a) The supervisory authority has the powers and resources to establish and enforce regulations and to communicate as appropriate with law enforcement authorities, as well as with other supervisors, to deter, detect, record, report and remedy fraud in insurance.
- (b) Legislation addresses insurer fraud.
- (c) Claims fraud is a punishable offence.
- (d) The supervisory authority requires insurers and intermediaries to ensure high standards of integrity of their business.
- (e) The supervisory authority requires that insurers and intermediaries allocate appropriate resources and implement effective procedures and controls to deter, detect, record and, as required, promptly report fraud to appropriate authorities. This function is under the responsibility of senior staff of the insurer and intermediary.
- (f) As required, the supervisory authority ascertains that insurers take effective measures to prevent fraud, including providing counter-fraud training to management and staff. The supervisory authority promotes the exchange of information between insurers with respect to fraud and those committing fraud including, as appropriate, through the use of databases.
- (g) The supervisory authority co-operates with other supervisory authorities including, as appropriate, in other jurisdictions in countering fraud.

Appendix B – Examples and cases of (alleged) internal fraud in insurance

Internal fraud includes a wide range of activities varying from straightforward theft, obtaining property by deception, data security breaches, breach of confidentiality and conspiracy, to attempts to obtain a pecuniary advantage by deception. Fraudulent and proper activities are often mixed and make the identification of internal fraud more difficult.

Theft or misuse of data for use in identity fraud and impersonation feature high on the list. Other types of internal fraud include:

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

Some typical cases of internal fraud that have occurred or could occur within insurers include the following:

Case 1 – False employment history

An application for employment contains material falsehoods. The applicant claims to have just returned to the UK after a year travelling abroad. Investigation reveals that the employee was working in the UK during the previous 12 months and had been dismissed for fraud. Other examples could be the inclusion of qualifications not held, a false employment history, a false reference or the use of a false identity.

Case 2 – Falsification of claims

An insurer from the UK was defrauded by an employee for the amount of £ 1.5 million. This involved inflating the value of claims filed with the company and siphoning off the excess.

Case 3 – Theft of information

An employee reports witnessing another employee print confidential customer data and placing it in a bag. Investigation reveals that the employee had been offered money for the information while out for lunch one day in the company's uniform.

Case 4 – Intellectual Property Fraud; Computer Technician gets seven years in jail for stealing

Miss T. was a computer data entry technician for an insurer. She used her position to order the issuance of 42 claim drafts, for in total more than \$207,000. These were subsequently mailed by computer from the insurer to T. at three separate addresses. She was arrested and charged.

Case 5 – Claims supervisor found guilty of theft

Mr S. was found guilty on theft for making fictitious claim payments to non-existent people. Mr S was creating claimants, manufacturing claims, authorizing payments and negotiating company drafts with the help of a niece, a teller at a local savings and loan association. Mr S. would call his niece each time he had worked the scheme to the point of draft issuance, and tell her the claimant would be in shortly, and ask her assistance in cashing the draft.

Case 6 – Office manager arrested

Mr P. was employed as office manager for an underwriting company. He was arrested and charged with the theft of \$97,055, which should have been forwarded to an insurance company. The underwriting company was a general agent for the insurance company.

Appendix C – Potential internal fraud indicators – red flags

The existence of these warning signs or indicators does not mean that internal fraud has occurred or will occur. Nevertheless, insurers should be looking out for these warning signs or indicators, particularly when more than one occurs.

Business practices and condition

- Management turnover is high.
- Staff turnover in financial and accounting departments is high.
- Insufficient information is available about prior audits.
- The internal control structure is weak.
- Management operations and financial decisions are dominated by a single person or by several people who generally act together.
- Tasks and/or transactions are very complicated, requiring special skills.
- There are indications of financial trouble, for example, inadequate capital or increase in unpaid debts.
- Accounting principles are changed, revising an accounting estimate or a delay in issuance of financial reports prior to obtaining financing or another major event.
- Costs are rising unjustifiably or costs are substantially higher than costs from comparable business units or competitors.
- Training programmes are weak.
- The organisational structure is too complex.
- Internal audits do not exist or are weak.
- The board of directors has a very high proportion of executive directors.
- Members of the board of directors, management or staff have external business interests and/or cosy relationships with contractors.
- Complaints or signals are received from external parties (like suppliers or customers) and/or there are missing statements and unrecognised transactions.
- Security systems for data and assets are weak.
- Sudden changes are made to the insurer's strategy.
- Assets are restructured without explanation (for example, significant changes in non earning assets).
- Accounting is poor.
- Financial results and ratios do not correlate.
- Inexplicable changes in share value occur.
- Transactions, processes or expenses are poorly documented.
- Transactions are unusual as to time (for example, day of the week, season), frequency (too many, too few), place (too near, too far out), amount (too high, too low, too consistent, too different) and parties (related parties, strange relationships).

- Excessive credit adjustments (quantities and price) to a particular vendor occur and/or credit is issued by an unauthorized department.
- Procedural manuals for departments and/or divisions are lacking or not complied with.
- The board of directors, management or staff act in a dual role that leads to conflicts of interest (for example, acting as the internal auditor and claims manager).
- Unusual commission structure exists.
- Activities are not consistent with the insurer's stated policies.

Indicators in relation to (personal) conduct or attitude

- The board of directors or management place undue emphasis on meeting earning projections.
- Insurer's earning ability is lower than that of other comparable insurers.
- Insurer faces adverse legal conditions.
- The board of directors and management display a propensity to take undue risks.
- Directors of the board, managers or members of staff have personal debts or financial losses incommensurate with their level of income.
- Directors of the board, managers or members of staff appear to be living beyond their means.
- Directors of the board, managers or members of staff suddenly change their life styles.
- Directors of the board, managers or members of staff feel great pressure from family, peers or society or appear to undergo marked personality changes.
- Directors of the board, managers or members of staff believe that they are being treated unfairly (for example, passed over for promotion, refused pay rises or staff displacement).
- Directors of the board, managers or members of staff appear to exhibit extreme greed for personal gain.
- Fees for or expenses of the board of directors and/or management are high or have increased significantly.
- People suffer from a condition (for example, addiction to drugs, alcohol, gambling) causing possible financial debts or difficulties in controlling personal debts.
- Morale is low within the insurer or within certain departments of the insurer.
- Inappropriate relationships exist at work or people act in an unusual manner (for example, evasive behaviour, unexplained curiosity of people over financial controls, etc.).
- There are problems in recruiting staff.
- There have been instances of irregularities in prior years.
- Board of directors and/or management do not provide satisfactory answers to the supervisor's or auditor's questions or do not allow staff to speak to supervisors or auditors.
- Board of directors and/or management's reputation in the business community is poor.
- Board of directors and/or management display an overly aggressive attitude toward financial reporting.

- Management fails to follow proper policies and procedures in making accounting estimates.
- Board of directors and/or management place undue pressure on the auditor.
- Board of directors and/or management do not comply with laws and regulations.
- Board of directors and/or management display a dominant management style that discourages critical or challenging views from others such as staff.
- Managers or members of staff are working late, are reluctant to take vacations and seem to be under permanent stress.
- Payments are processed late in the day or after normal business hours.
- Payments are made in such a way that prescribed authorisation of others is avoided (for example, dual payments below the authorized payment level).
- Sales personnel provide coverage below market rates.
- Payments to third parties are made without appropriate supporting documentation.
- Insiders reduce their holdings of the insurer's stock.

Appendix D – Cases of (alleged) policyholder fraud and claims fraud in insurance

Exaggerating damages or loss

Case 1 – Overcharge for damage repair

A report published by the California Bureau of Automotive Repair in 2002 indicated that of over 500 vehicles inspected after repairs, more than 40% of the bills included charges for work never done or for parts not used. The average overcharge was \$586, (one-sixth of the average auto insurance claim after an accident).

Staging the occurrence of incidents

Case 2 – Staging car accidents by criminal gangs

Car accidents staged by criminal gangs are costing insurers millions of UK pounds each year.

In one example, a criminal group will arrange for a fee of £500 an accident for the fraudster, often at a roundabout, involving an innocent driver. One of the criminals will use the identity documents of the fraudster to impersonate him. The fraudster will subsequently file an insurance claim. The criminal group would also provide a fake medical report for a whiplash claim. Apparently, the average payout on a staged accident was £3,000, often with a £2,500 claim for whiplash damage.

In another example, a fake car crash could be staged for less than £2,000. Two drivable cars could be bought to stage a crash for £1,000. For an extra £800 a customer could buy £500 of comprehensive insurance, and another £300 of third party cover. After a fake crash had been staged all participants could claim £2,500 for whiplash injury and £5,000 for the written-off cars, fake car hire and loss of earnings. This way, fraudsters could collect on a £26,000 claim.

The Insurance Fraud Bureau estimates that it costs insurers between £48 million and £200 million a year. Apparently, the success rate for criminals is high since the police authorities do not have sufficient time to investigate.

Case 3 – Staging a car accident after illegal racing

A new car under comprehensive motor cover is used in illegal car racing, which depreciates its value rapidly. The policyholder stages a car accident in the presence of independent witnesses. He would then claim compensation from the insurer for damage to his car.

Reporting and claiming of fictitious damage or loss

Case 4 – False mobile phone thefts

In Britain the police force receives 160 false reports of mobile phone thefts a month, which costs it £1 million a year to investigate. The National Mobile Phone Crime Unit estimates that between 15-20 per cent of mobile phone theft reports in the UK are false. Police suspect that false claims are sometimes encouraged by unscrupulous mobile phone shop staff looking for extra commission. Sometimes someone who has lost their phone will falsely report it as stolen in order to claim on their insurance. People think they're doing nothing wrong in lying to police and insurers.

Case 5 – faked theft of a cruiser

A man has been accused by police of staging the theft of his 39-foot yacht and was charged with insurance fraud, tampering or fabricating physical evidence, theft by deception and making false reports to law enforcement.

Authorities allege that T.L. faked the theft of his cruiser from a marina.

The boat was found later at the L. yacht club in E., Ohio. It was missing a flat-screen television, a cabin table, an anchor and a large piece of carpet, according to a criminal complaint.

Medical claims fraud

Case 6 – staged motor accident ring

An insurer in the US filed a lawsuit alleging that 67 chiropractors, doctors, medical corporations and individuals used a staged motor accident ring as a source of patients. The lawsuits claimed \$14.1 million in restitution of paid claims and a further \$42 million in damages.

Case 7 – claims for services not rendered

A 54-year-old man was charged with fraud and money laundering in connection with an investigation of a doctor who improperly prescribed painkillers.

G. W., a licensed chiropractor, was charged by the Pennsylvania Attorney General on Thursday for improperly billing the state Medicaid system for physical therapy sessions that were not supervised by a doctor or licensed physical therapist, according to the police

Mr. G. W. allegedly allowed patients to use a gym for “physical therapy” without assistance or direction from a licensed doctor. He billed the state Medicaid system, although law requires a direct supervision from a licensed physical therapist or a doctor, according to the complaint.

A woman who was contracted to do medical billing for the office, became concerned when she noticed there was no supervision and no “blood pressure cuff, scale, stethoscope or medical waste box” at the L. office, according to the complaint. The woman refused to do medical billing until the physical therapy sessions were being properly supervised, according to the complaint.

Mr. G. W. is charged with nine felonies. He faces more than 20 years in jail and nearly \$200,000 in fines

Case 8 – miscoding

The victim in this case is a US-based Fortune 500 company that operates a self-funded health care plan for its employees. The plan is administered by an outside health insurance company to which claims are submitted.

The fraud perpetrators include two individuals operating a health care clinic in California (as it happens these two individuals had “records” of securities fraud and for sexual misconduct with multiple patients, respectively). In addition to the above there were approximately six surgeons and laboratories involved in the fraud.

It first came to light when an employee reported that an unusually large number of employees were having cosmetic surgeries (not covered under the plan) performed at the expense of the company’s health care plan. This was affected by miscoding, booking an operation as “the removal of painful scar tissue” when the operation performed was actually a “tummy tuck” or “liposuction”.

Over the three years of fraudulent operation over US\$ 1 million was paid out to the clinic.

Claims fraud related to money laundering

Case 9 – arson by a drug syndicate

A syndicate of drug barons bought a gold refining plant in Florida, insured with Lloyds’, and burnt it down partly in order to launder “dirty” monies.

Claim related to terrorist financing

Case 10 – Insurance Policies to Support Terrorism

In 2004, students and brothers Yasser Abu S. and Ismail Abu S. were recruited to be members of a terrorist organization. Yasser Abu S. was apparently scheduled to perform a suicide bombing in Iraq. The suspects allegedly earned money through life insurance fraud to support international terrorism. Officials said they attempted to raise money by taking out an 800,000 Euro (\$1 million) life insurance policy on Yasser, who intended to fake a fatal traffic accident and use the money for terrorist purposes. They were accused of 10 counts of fraud and 23 counts of attempted fraud.

Different types of fraud reported via a “cheat line”

Case 11 – Cheat line’ turns tables on commen

The Association of British Insurers (ABI), which set up a “cheat line”, reported a sharp increase in the number of people reporting false insurance claims and indicated that these reports have saved insurers millions of pounds. One insurer estimates that it has saved £1.5 million as a result of information received from the hotline.

A third of calls relate to household insurance, mainly fictitious burglaries or deliberate fires. Another third involve car accidents. Some 17 per cent concern bogus personal accident claims, with one in 10 callers informing on companies making dubious commercial claims.

In one case a £60,000 claim for a written-off Ferrari was rejected when someone reported that the accident had happened at a rallying event.

Fraud by a third party involved in the settlement of the claim

Case 12 – Independent adjuster arrested in shakedown scheme

Mr. B., an independent adjuster, was hired by an insurer to conduct an inventory at a retail department store, after the store had been burglarised. The owner of the store, who cooperated with the investigation, had reported a loss of \$33,599 to his insurer. The investigators electronically monitored conversations between the owner and Mr. B, wherein Mr. B. stated that he had figured the loss to be much lower than reported, but offered to “inflate” his inventory in return for 7%. B. agreed to a cash payment of \$2,000. When Mr. B. was overheard accepting the payment from the owner, he was placed under arrest.

Appendix E – Potential policyholder and claims fraud indicators – red flags

The existence of these warning signs or indicators does not mean that fraud has occurred or will occur. Nevertheless, insurers should be looking out for these warning signs or indicators, particularly when more than one occurs.

General

Claimant's behaviour

- The claimant is aggressive when applying for a policy. When making a claim he/she is very demanding and/or insists for quick settlement.
- The claimant enquires frequently about the progress of the claim handling.
- The claimant threatens to bring in a lawyer if the claim is not settled swiftly.
- The claimant wants cash.
- To deal with the claim quickly, the claimant is willing to accept an inexplicably low settlement.
- The claimant did nothing to prevent or limit the damage.
- The claimant is unwilling to co-operate during a reconstruction and/or gives evasive answers.
- The claimant handles all business in person or by phone, avoiding written communication.
- The claimant does not want other people, for example, family, friends and neighbours, to know what happened.
- The claimant gives inconsistent statements to the police, experts and third parties.
- The insured has detailed knowledge about insurance terms and the claim process.
- The insured has checked the insurance coverage shortly before the claimed event.
- The policyholder has several policies with the same insured object and coverage.
- The insured requests that payment is made into different accounts.
- The insured changes address, bank or telephone details shortly before a claim is made.
- The claimant request payment to be made to a third party.
- The claimant insists without proper reason on using certain contractors, engineers or medical practitioners or wants to use relatives.
- The way a claim is filed is remarkable (for example, the claimant used a lawyer or sought professional advice in claims reporting).
- The policyholder changes insurer frequently.
- The policyholder has been denied insurance before and has not mentioned this when applying for insurance.
- The policyholder insists on changing terms and conditions.

Documents

- The claimant is not able to provide documentary evidence for major losses, such as receipts or photographs (and minor losses are documented).
- Documents, for example, receipts, are not specific or the name of the buyer is filled in later. Documents are changed or are unreadable.
- Original documents/receipts are missing, only copies are provided.
- New receipts (not wrinkled, very clean) are provided for old events or products.
- There is different handwriting on various receipts.
- The dates on documents are strange (for example, in relation to holidays, business hours etc.).
- Receipts are provided from companies that do not exist, have ceased operating or are insolvent.
- Receipts with differing dates have successive numbering.
- The currency on foreign receipts is not specified.
- A “pro forma” receipt is provided.
- The application form is not completely filled in and/or not signed.
- The claim form is not completely filled in and/or not signed.
- Alterations are made in the claims form to create appearance of cover.
- There is a big difference between the receiving date of the application form and the inception date of the cover.
- There are inconsistencies between the application form and the claim form.
- There are variations in or additions to the policyholder's initial claims.
- Supporting documentation is supplied by parties related to the insured or claimant.
- Reports from medical practitioners or others (for example, police authorities) are inconsistent.
- Documentation from foreign countries deviates from the expected format or contents (for example, use of incorrect language).

Characteristics of losses

- The claim is filed either shortly after coverage becomes effective, or just before cover ceases or shortly after the cover has been increased or the contract provisions are changed.
- The loss occurs just after payment of premiums that were long overdue.
- Damage has occurred in the period of provisional cover.
- The loss was not reported abroad where it occurred.
- There are inconsistencies between the insured amounts and the characteristics (for example, age, profession) or life style of the insured.
- Actual loss is far higher than first reported loss.
- Claimed loss is just below a threshold that causes additional checks by the insurer.
- The insured interest is questionable.

Characteristics of claimant

- The insured's financial situation is bad.
- The insured lives in a known fraud area.
- The policyholder or claimant has a relationship to known fraudsters or criminals.
- The insured's family situation is difficult (for example, recently divorced).
- The insured's occupational situation is unusual and/or difficult (for example, he/she is unemployed or self-employed, frustrated with the job, facing disciplinary action and/or revocation of professional licensing, a seasonal worker where the active labour season is coming to close, or employed in an industry or company that is experiencing lay-offs or downsizing).
- The claimant uses a post office box or hotel as his/her address, has moved a lot, gives a false address, or his/her telephone number does not match the address.
- The policyholder is the partner of the claimant.
- The claimant has a bad claims history.
- There is a certain connection between the claims.
- The identity of the policyholder, the insured or beneficiary cannot be determined.
- The insured frequently makes high claims.
- The insured will not disclose his claims history (with other insurers).
- The claimant insists the payment should exceed the value of the damaged goods.
- Claims are submitted by a third party without proper power of attorney.
- The claimant cannot be contacted through normal channels.

Property claims (including disaster fraud)

A major disaster provides an ideal opportunity for fraudsters. Insurer's resources are stretched due to the large number of claims, so that they are not able to evaluate claims as thoroughly as they normally would.

- Losses fit in badly with the insured's characteristics, such as residence, occupation, income and/or lifestyle.
- A large amount of cash has been stolen.
- According to the claimant, the insured claims items were new.
- The claimed items are (substantially) over-insured.
- No police report is provided in cases where you would expect one.
- The insured is unable to describe the losses adequately.
- At the preliminary stages of the claim, the insured gives a very detailed description of the property or has a detailed photo report.
- The damaged items are not/cannot be examined by the loss adjuster.
- There are unexplainable differences between the claimed losses and the findings in the police report.
- The insured's items were up for sale.
- An insured company has expansion plans.

- The insured items were in bad shape.
- The order of the list of property provided by the claimant is exactly the same as in the loss adjuster/claim inspector's report.
- During a fire or other disaster neighbouring buildings were not affected.
- Coincidental absence of the insured, family or pet at the time of a fire is suspicious.
- Detailed investigation makes it clear that no sentimental items (such as photograph albums) or family heirlooms were lost or damaged.
- Characteristics of the losses are incompatible with the season in which the losses are claimed.
- There is no physical evidence of the place where heavy items were located (like indentations in the carpet from furniture).
- More than one source of fire is found.
- The origin of the fire is unknown or conspicuous/suspicious.
- In case of arson there is no evidence of burglary.
- At the time of the fire the building was unoccupied and without surveillance.
- At the time of the fire the building was not connected to public utilities.
- The fire was not detected by the fire alarm.
- The fire alarm was "coincidentally" switched off.
- The fire alarm was switched on, but "blocked" by objects.
- The fire is detected shortly after people have left the building.
- Vehicle theft and casualty/damage
- These types of fraud normally occur when the claimant exaggerates the car damage and/or his injuries, totally fabricates claims or stages an accident.
- The claim involves victims with no own damage insurance and/or one who would be at risk if found at fault.
- One of the people concerned reports a suspicion of a set-up.
- The insured was involved in accidents before, with similar circumstances and/or with the same lawyer.
- The insured (too) easily agrees to accept the blame.
- There are inconsistencies in the claimant's account (for example, who was driving and what the final destination was).
- After an accident with substantial damage, the police and/or emergency services were not called.
- After an accident with substantial damage, a claim for recovery damage was not made.
- The passengers of one of the vehicles involved did not have personal relationships with each other.
- There is a relationship between the people involved (for example, between passengers of the different vehicles or between passengers and doctor).
- One of the people involved has a rental car.
- The driver of the rental car accepts blame easily.

- The witness is very co-operative.
- An old car bumps into a new car.
- Severe damage is incurred without a collision (for example, swerving).
- Both people involved are foreigners from the same country.
- There are several very similar testimonies or striking differences between the testimonies.
- There are remarkable similarities in the reported injuries, the medical reports or the repair shops or doctors involved.
- The damage does not match the injuries (for example, little physical damage but severe personal injuries).
- There are inconsistencies in the damage of the involved cars (one with minor damages, the other with severe damages).
- The injuries, such as headaches or whiplash, cannot be objectively observed.
- There are no marks at the location of the accident.
- The accident took place at a deserted location.
- The claimant's employment information is suspicious.
- The claimant started his employment shortly before the accident occurred.
- There was a delay in filing the accident claim.
- The date of modification is too close to date of accident.
- The claimant does not want the claim handler to contact his employer directly.
- The car has an unusual registration number.
- The registration number had just been registered.
- The car is stolen just after the end of the "new-value period".
- The car theft took place where parts of the registration certificate were in the car or were lost before the theft.
- The car keys are not the original ones.
- There is an unclear story about the use of the key.
- The alarm was switched on but did not work.
- The stolen car is recovered completely undamaged (or locks are not damaged).
- The stolen car is recovered with valuables/documents.
- There is inconsistency between the age or social position of the insured and the type of the car.

Travel

- The insurance term does not match the holiday period.
- Insurance is only bought for the days of journey, not for the stay.
- There is inconsistency between the loss and the living standard or the amount of luggage of the claimant.

- The loss is reported a long time after the trip.

Life

- The insured dies abroad.
- The body of the deceased is not found or identified.
- The (original) death certificate is not available.
- The cause of death or disability is suspicious.
- A claim of suicide or a criminal offence arises shortly after inception of the policy.
- Policy provisions or beneficiary are changed just before death or disability.
- Payments are requested to be made to others rather than the policyholder, the insured or the beneficiary.
- The premium is paid in cash.
- The premium is paid in foreign currencies or from a foreign bank account.
- There is inconsistency between insured amount and standard of living of the insured.
- There is a large age difference between insured and beneficiary.
- The policy is cancelled or a refund of premiums is requested shortly after the cooling-off period.
- The application is just below the limit that would trigger a more detailed examination of the application.
- A disability claim arises just after a premium default.
- The relationship between the policyholder, the insured and the payer of the premiums is unclear.
- One policyholder or beneficiary has several policies with different address data.
- The policyholder accepts unfavourable conditions.
- A request for cancellation is not signed or is signed by an unauthorised person.
- There is an inconsistency between the beneficiary's name and account number.
- Early surrender or encashment of the policy especially if against unfavourable conditions (for example, loss of tax benefits or deduction for expenses made by the insurer).
- The beneficiaries are changed frequently.
- Payments are made to unrelated third parties.

Transport

- A high quantity of goods is stolen given the available time frame.
- Packed goods are repacked to larger volume entities, for example, pallets.
- The endorser is different from claimant.
- Transportation is to final destination that does not have a market or proper processing facilities.
- There are gaps in the dossier.

- Goods to be transported to developing countries are overvalued.
- Intermediaries do not cooperate.
- The tachometer is damaged or missing.
- The parties in the transport sector have bad reputations.
- The weighbridge is not calibrated.
- There are inconsistencies between the insured amount and market prices.
- There are inconsistencies between the insured volume/weight and the real weight.
- There are inconsistencies between the insured volume/weight and the type of goods.
- Goods are delivered (at a later date) after theft.
- The drivers are paid per trip.
- The policyholder is different from the applicant for provisional cover.
- Documents are put ready in hotels or restaurants without sufficient supervision.

Healthcare

- Improper identification numbers are used.
- The diagnosis is incorrect or the adjuster receives conflicting medical opinions from medical providers.
- There was no communication with emergency services.
- Prescriptions are cut or have been altered.
- The claimant has multiple disability policies.
- The treatment being provided to the claimant is inconsistent with the report diagnosis.
- The claimant is involved in active employment or in a physical sport or hobby although he claims his disability prevents him from engaging in sedentary work.
- Treatment dates appear on holidays or other days that medical facilities would not normally see patients.
- The claimant later develops additional injuries allegedly related to the initial injury or illness when it appears the claim will be terminated.
- Medical terminology on the documents is misspelled or misused.
- The claimant changes attending physicians frequently.
- The attending physician is not in the same geographic region as the claimant.
- The attending physician's specialty is not consistent with the diagnosis.
- The claimant's illness or injury occurs shortly before an employment problem (for example, disciplinary action, demotion, layoff, strike, termination, or down sizing).

Appendix F – Specific cases and examples of (alleged) intermediary fraud in insurance

The most common example of intermediary fraud is where an intermediary takes the premium from the purchaser and does not pass it to the insurer resulting in no insurance cover being in force (premium diversion). This can go on year after year, especially where the intermediary has delegated powers, with the policyholder not becoming aware of the situation until a claim is made.

A variation of this is where an intermediary inflates the premium, passing on the correct amount to the insurer and keeping the difference as well as earning any commission due on the transaction.

Another example is non-disclosure or misrepresentation of the risk to reduce premiums in order to win the business. Again the policyholder only discovers this when a claim is made which can be years later.

These frauds can have subtle variations:

- Alleged cover does not exist as the premiums have been stolen by the intermediary and not passed on to the purported insurer. The result is the purported insured loses his/her money.
- Alleged cover does exist but the premiums have been stolen by an intermediary who has binding authority. The result in this case is the purported insured would be covered due to ostensible authority issues but the insurer loses out as it has to provide cover for which no premium has been received.
- Alleged cover does not exist with the purported insurer or has been placed with a sub-standard or fraudulent insurer. Policyholders are then not covered by the insurer named in the policy documentation and claims may not be met by the actual insurer.
- Alleged cover does not exist and the intermediary intends to act as insurer and pay claims. The result would be that some insured persons would have their claims paid and some may not. As intermediary runs out of premium to pay the claims, the tendency is to seek more and more policyholders to cover the losses. When the scheme finally collapses there are a large number of victims.

Commission fraud by an intermediary occurs when insuring non-existent policyholders while paying a first premium to the insurer, collecting commission and annulling the insurance by ceasing further premium payments.

Also, intermediaries might collect commission from the insurers and at the same time charge the insured a consulting fee (in some jurisdictions this would be illegal).

Case 1 – Commissions and “bid rigging”

A civil complaint was filed by the New York Attorney General against M. The allegation was that for years M. received payments from insurers that were in addition to upfront sales commissions, so-called “contingent commissions” and that fake bids or quotes were solicited, which may not have been competitive.

The complaint refers to internal communications in which executives discuss how to maximise M.’s revenue and insurers’ revenues (without regard to the clients’ interest). An example of such a communication was allegedly the message: “We need to place our business in 2004 with those (insurers) that have superior financials, broad coverage and pay us the most”.

Major insurers were named as participants in steering and bid rigging.

According to the complaint, M. collected approximately \$800 million in contingent commissions in 2003. The civil complaint tries to end the steering and bid rigging.

In January 2005, M. reached a settlement agreement with New York. As a result, the company enacted reforms to address the complaint. Under the terms of the agreement, M. neither admitted or nor denied the allegations in the complaint. M. agreed to forgo contingent compensation and to disclose all forms of compensation received from insurers. Also, M. will provide all quotes and terms received from insurance carriers and adopt a compliance and conduct policy for the firm. A fund also was created to compensate clients. However, the fund did not represent a fine or penalty.

The investigation implies that the mere existence of contingent commissions leads to the misconduct. However, many independent insurance agents and brokers in the U.S. receive contingent commissions for placing quality business with carriers without allegations of misconduct. Under the terms of the settlement, M. was not fined or penalized for receiving contingent commissions.

It is important to note that no regulator or government official has ever said or found that contingent commissions are per se illegal or impermissible. In fact, in all of his carrier settlements, carriers are expressly permitted to continue to make such payments. In addition, none of the actual claims in the complaint turn on the payment of contingent commissions.

Case 2 – Fictitious valuations

Another example concerns one of the principals of an intermediary firm who deliberately provided wrong information regarding the value of policies to clients.

This individual had been providing investment services from 1997 to two particular structures on behalf of two American business partners. The portfolios held approximately \$3.5 million and \$3 million at the outset. The clients and USA advisors had sought target growth of 12 – 15% p.a. They stipulated that they would require fixed annuity payments from the companies of approximately \$300 thousand each. There is a further structure that has also been administered by the intermediary which had an initial investment of approximately \$600 thousand.

The intermediary managed to achieve the required growth for the main portfolios in the first year but failed to reach the targets from about 1999. Instead of reporting this to the clients he falsified the valuations in the hope that the portfolios would bounce back. The investments not only failed to reach targets but actually fell in value. The capital was being eroded further by the annuity payments continuing to be maintained. He continued to provide the false valuations over a period of years until he ran out of investments with which to pay the clients' annuities in January 2004. At this point he reported the matter to his legal advisers, who in turn advised him to report it to the supervisor.

By his own admission, he had been providing false investment statements over a prolonged period of time. He did not take the opportunity of coming clean until it was clear that the cover up could not continue. Although he claims not to have profited out of the manipulation of the investment portfolios, the fact that the intermediary charged a fee of 0.5% of their (false) value means that he has benefited indirectly.

There was no supervision of the adviser, who kept the client file locked away and did not allow any administrative staff or the other principal of the business to handle the file according to procedure.

Case 3 – Backdated cover

An investigation into a firm was carried out where allegedly the intermediary was backdating motor insurance policies to give motorists the appearance of insurance coverage after an accident had already occurred. In exchange for this illegal activity, the agent/broker demanded a fee. In this

case some applicants were charged up to \$3,000 for a backdated policy. Numerous claims were investigated from three affected insurers.

Case 4 – A bogus insurance programme

An intermediary based in the US collected \$3.8 million in a nationwide bogus insurance programme. The intermediary was arrested and charged on 63 counts relating to the sale of thousands of fake insurance policies throughout the US.

Case 5 – Fraud against a reinsurer

In this case the premium for reinsurance was far less than the ceding insurer knew it would have to pay out as claims.

The fraud

The fraud occurred in the reinsurance market of the personal accident element of US Workers' Compensation business. The market was found to comprise a handful of players, based primarily in London and Bermuda, who were prepared to write what they knew to be gross loss making business relying on their reinsurance to make net profit. This kind of underwriting involves no real assessment of the risk and has been referred to as "arbitrage" or "net underwriting". The judge described the market as being like a game of "pass the parcel" and as being economically unsustainable as each player passed certain losses on to his reinsurers who did the same to their reinsurers. Characteristic of the market is the creation of spirals as losses, rather than being dissipated by outwards reinsurances, are concentrated on certain insurers higher up the chain. Inevitably, the market ended in disaster and the losses sustained in relation to this action alone stand at \$250 million and rising. The court held that a market that traded in losses of this type was one in which no rational and honest person would have participated if he had understood the market and proper disclosure had been made. Documentary evidence showed that the true nature of the business was deliberately and fraudulently concealed.

Involvement of the underwriter

S. had granted a binding authority to their underwriting agent E. at a time when E. had already been in discussion with the brokers S. about using the binding authority to write Workers Compensation carve out business. It was found that when S. granted the binder to E., the nature of the business which the E. underwriters intended to write was fraudulently misrepresented to S. and that at no time was S. told the true nature of the business being written by E. Of 119 contracts written under the binder, 112 of them were broked by S. Those 112 contracts generated premiums of \$25 million but the losses amounted to in excess of \$250 million. The E. underwriter confirmed in his evidence that he wrote the contracts in the expectation that he would be able to recover most of the losses from reinsurers.

Involvement of the broker

It was also found that S. knew that E.'s acceptance of the programs was dishonest and in breach of E.'s duties under the binding authority, and that S. had therefore dishonestly assisted E. in breaching those duties. The judge described the actions of S. and E. as: "a chronicle of deception that induced insurers to become involved in a business in which they would have never have been involved if the business had been properly explained to them".

Involvement of the reinsurer

However, whilst the judge found no dishonest conduct on the part of anyone at S., he did find that the conduct of the underwriter at S. responsible for agreeing and supervising the binding authority had: "fallen well below that which was to be expected of any competent underwriter; if he had not

acted with such gross negligence and dereliction of duty (which S.'s internal controls failed to prevent), the dishonesty of E. and S. would have been investigated long before it was". S.'s holding company was considering an appeal: "To characterise S. as a victim in this is preposterous. They were part of the market; they knew what was going on. I think the judge saw himself charging in on a white horse and took offence to the way this slightly wacky world of reinsurance operates".

Case 6 – Agency owners sentenced for theft

Mr W. and Mr C. were co-owners of an agency company. It appeared that \$277,004 premium, paid to the agency by a School Board, had never reached the insurer. The School Board's premium was for fleet and multi-peril coverage. After being notified of a rate increase, the School Board decided to reject the offer and advertise for new bids. The insurer then notified the School Board that its premium of \$197,532 was past due. Investigation determined that the \$270,004 cheque from the School Board had been deposited into a money market account of Mr W's agency company. The bank records were subpoenaed; the records were obtained; the money was gone! Where the money had gone, was unimportant. Where it not had gone (the insurer) formed the basis for the charge of theft. A detailed audit turned up some other cheques he "forgot" to forward to the company.

Case 7 – Premium for \$22,000,000 in insurance for hotels

Mr L, an insurance intermediary, accepted a premium of \$408,570 to place \$ 22,000,000 in property and liability insurance for a hotel group. One cheque was issued for the entire premium, on behalf of the six hotels. Mr L. deposited this cheque into his account and used approximately \$77,000 of it to buy some insurance for the hotels. Unfortunately for the hotels, Mr L. had a lot of personal debts. He used the "change" (about \$170,000) to buy himself a boat and a condo. L. admitted manufacturing and altering several documents to indicate the proper amount of coverage for the premium paid by the hotel group.

Appendix G – Definitions for the IAIS Glossary of Terms

Churning: the activity undertaken by an insurer or intermediary in which various insurance policies are sold to a single policyholder without a proper need for the insurance cover by the policyholder concerned. This practice is aimed at creating a bigger turnover – often to generate commission – and is generally illegal or at the least regarded as immoral.

Claims fraud: Fraud against the insurer in the execution of an insurance product by obtaining wrongful payment

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

- misappropriation of assets and/or insider trading
- deliberate misrepresentation, concealment, suppression or non-disclosure of one or more material facts relevant to a financial decision, transaction or perception of the insurer's status
- abuse of responsibility, a position of trust or a fiduciary relationship.

Intermediary fraud: Fraud by intermediaries against the insurer or policyholders.

Internal fraud: Fraud against the insurer by a director of the board, a manager or member of staff (regardless if the member of staff is employed on a permanent or temporary basis) on his/her own or in collusion with others who are either internal or external to the insurer.

Policyholder fraud: Fraud against the insurer in the purchase or in the execution of an insurance product by obtaining wrongful coverage or payment.

Product proofing: development of an insurance product in such a way that fraud risk and other relevant risks are recognised and dealt with using adequate control measures.

Red flag: an indicator that suggests the need for more detailed investigation of a fact, event, statement or claim. It may – especially in combination with the occurrence of other red flags – indicate potential fraud.

Whistle blowing: the exposure and reporting of fraud by a member of the public or within an insurer by a director of the board, a manager or a member of staff.