

INTERNATIONAL ASSOCIATION OF INSURANCE SUPERVISORS



REPORT ON THE SURVEY ON PREVENTING, DETECTING AND REMEDYING FRAUD IN INSURANCE

MAY 2007

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Management summary

In 2006, the International Association of Insurance Supervisors (IAIS) published the *Guidance paper on preventing, detecting and remedying fraud in insurance* (guidance paper). The guidance paper was written by the IAIS Insurance Fraud Subcommittee (IFS) to assist the supervisors to address fraud risk management in insurance and to assist insurers and intermediaries in the prevention, detection and remediation of the potential risk of fraud. To improve the draft guidance paper a survey questionnaire was developed and sent to IAIS Members and Observers and to the members of the International Association of Insurance Fraud Agencies (IAIFA)¹. This report describes the results of the survey.

For the purposes of the guidance paper and the questionnaire, fraud in insurance is defined as follows: an act or omission intended to gain dishonest advantage for the fraudster or for the purposes of other parties. Within this definition, three fraud categories were distinguished: internal fraud, policyholder and claims fraud and intermediary fraud. The questionnaire contained questions to validate, with practicing experts in the insurance industry, the assumptions made in the guidance paper. Furthermore, the respondents were provided the opportunity to describe additional reasons, indicators or measures with the purpose of identifying elements not covered in the paper. At the end, the questionnaire contained open questions about the experience of the respondent and about the main problems in the battle against fraud.

The IAIS received 106 responses to the survey questionnaire, of which 52 were completed by insurers, 7 by trade associations, 42 by supervisors and 5 by other organisations. The respondents came from close to 50 countries or regions of the world.

The questionnaire provided a positive contribution to the development of the guidance paper by supplementing the draft version with additional fraud indicators and anti-fraud measures and, most importantly, by corroborating the initial findings of the research. It also resulted in a broad overview of the current problems that insurers and supervisors experience in the battle against fraud. The survey resulted in the following conclusions:

- Both insurers and supervisors have a broad approach in managing fraud risk. Fraud is managed not only because of its direct financial impact, but also because of integrity aspects. The direct costs of fraud, the reputation risk, supervisory requirements and ethics are all important reasons.
- For all categories of fraud, fraud risk indicators (or “red flags”) are available. Checking red flag lists is considered a useful anti-fraud measure, especially when the process can be automated. Fraud risk indicators of internal fraud can come from different sources, from inside or outside the insurer and in different stages of the organizational processes. Therefore, it is important to create awareness and to implement anti-fraud measures throughout the whole organization.
- Fraud risk management contains some generic elements that are important for the management of internal fraud risk, policyholder and claims fraud risk and intermediary fraud risk. For all these categories, internal control and internal audit are seen as very important controls. More specific measures that are important to these categories are an anti-fraud policy, fraud awareness in the whole insurer, priority at board level and a central anti-fraud function.
- In addition, for each fraud category some specific anti-fraud measures are important. Physical and procedural safeguards and elimination of potential conflicts of interest are important to prevent internal fraud. For policyholder and claims fraud, product development, client acceptance and claim assessment are all important stages that should be addressed by anti-fraud measures. Information technology seems to play a growing role. For countering intermediary fraud it is crucial that insurers have clear

¹ IAIFA is an international organisation dedicated to fight fraud in insurance. Its members are representatives of the insurance industry, supervisors and the academic world.

procedures and that they “know their intermediary”. Communication, training, screening and auditing are crucial elements.

- On the last question on the problems that are encountered in the battle against fraud, respondents noted 234 issues. The responses have been categorised in six categories. Most of the problems have to do with inadequate risk management (34%). This category deals with different aspects of the risk management system: priority at board level, culture, an effective anti-fraud policy, fraud awareness, knowledge and training and internal control and internal audit. Other significant problem categories are ineffective regulation (provability and privacy law) and law enforcement (priority and capacity) (22%) and information sharing and cooperation (between insurers and between insurers and law enforcement and internationally) (15%). Public attitude (“fraud as a victimless crime”), commercial interests (prevailing above fraud prevention and detection) and opportunities related to the characteristics of insurance products (based on trust) and technology form the other categories, and represented 14%, 8% and 7% respectively of the answers. When responses from industry and supervisors are compared, the scores are not very different. Industry gives more weight to issues of ineffective regulation and law enforcement, where supervisors were more critical about fraud risk management. However, the proportion between the different categories does not change substantially.
- The good thing is that the insurance industry can influence and tackle some of the mentioned problems: inadequate fraud risk management, commercial interests and a lack of information sharing and cooperation. In many cases, individual insurers cannot do the job alone, but together they can make improvements. Also the public attitude can be influenced when insurers cooperate. When the insurers join forces, they also have a higher chance to influence regulation and the effectiveness and priorities of law enforcement. The supervisors can play a supportive role in these areas.
- Fraud occurs when there is a combination of opportunity, rationalisation and incentive. Via adequate risk management, cooperation, law enforcement and influencing public attitude important steps can be made in the battle against fraud.

1. Introduction

In 2006, the International Association of Insurance Supervisors (IAIS) published the *Guidance paper on preventing, detecting and remedying fraud in insurance* (guidance paper)². The guidance paper was written by the IAIS Insurance Fraud Subcommittee (IFS) to assist the supervisors to address fraud risk management in insurance and to assist the insurers and intermediaries in the prevention, detection and remediation of the potential risk of fraud. The IFS conducted research into fraud indicators and best practices to control fraud risks. In addition, it developed a questionnaire that was sent to the IAIS Members and Observers and to the members of the International Association of Insurance Fraud Agencies (IAIFA)³. The purpose of the questionnaire was to improve the draft guidance paper by taking advantage of the knowledge and experience of anti-fraud experts in the insurance industry and in insurance supervision. The survey does not pretend to give a scientifically or statistically well-founded conclusion, but it presents a broadly shared point of view concerning insurance fraud risk management issues. This report describes the results of the survey.

² Guidance paper on preventing, detecting and remedying fraud in insurance.

³ IAIFA is an international organisation dedicated to fight fraud in insurance. Its members are representatives of the insurance industry, supervisors and the academic world.

2. Conclusions

The survey questionnaire provided a positive contribution to the guidance paper by supplementing the draft version with additional fraud indicators and anti-fraud measures and, most importantly, by corroborating the initial findings of the research. It also resulted in a broad overview of the current problems that the industry and the supervisors experience in the battle against fraud. In this section some conclusion are presented about the different categories of the questionnaire. In the following sections, the underlying details are described.

Reasons for fraud risk management

Both the industry and the supervisors have a broad approach in managing fraud risk. Fraud is managed not only because of its direct financial impact, but also because of integrity aspects. The direct costs of fraud, the reputation risk, supervisory requirements and ethics are all important reasons. This applies to all the three fraud categories - internal fraud risk, policyholder and claims fraud risk and intermediary fraud risk. However, there are small differences: for policyholder and claims fraud, the direct costs are the most important, whereas for internal fraud the reputation risk is dominant.

Fraud risk indicators

For all categories of fraud, fraud risk indicators (or “red flags”) are available. Checking red flag lists is considered a useful anti-fraud measure, especially when the process can be automated. Fraud risk indicators of internal fraud can come from different sources, from inside or outside the insurer and in different stages of the organisational processes. Therefore, it is important to create awareness and to implement anti-fraud measures through the whole organisation.

Anti-fraud measures

Fraud risk management contains some generic elements that are important for all three categories of fraud. Internal control and internal audit are seen as very important controls. More fraud specific measures that are important for all fraud categories are an anti-fraud policy, fraud awareness in the whole insurer, priority at board level and a central anti-fraud function.

In addition, for each fraud category also some specific anti-fraud measures are important. Physical and procedural safeguards and elimination of potential conflicts of interest are important to prevent internal fraud. For policyholder and claims fraud, product development, client acceptance and claim assessment are all important stages that should be addressed by anti-fraud measures. Information technology seems to play a growing role. For countering intermediary fraud it is crucial that insurers have clear procedures and that they “know their intermediary”. Communication, training, screening and auditing are crucial elements.

Problems in the battle of fraud

Many problems are encountered in the battle of fraud. The good thing is that the insurance industry can influence and tackle some of them: inadequate fraud risk management, commercial interests that prevail above fraud prevention or detection and a lack of information sharing and cooperation. In many cases, individual insurers cannot do the job alone, but together they can make improvements. In addition, public attitude can be influenced when insurers cooperate. When insurers join forces, they also have a higher chance to influence regulation and the effectiveness and priorities of law enforcement. The supervisors can play a supportive role in these areas.

3. Survey questionnaire set-up and topics⁴

To be sure that all respondents used the same concepts, the survey questionnaire started with the definition of fraud as used in the draft guidance paper. Respondents were asked to give comments on this definition.

Definition of fraud

For the purposes of this questionnaire, fraud in insurance is defined as follows: an act or omission intended to gain dishonest advantage for the fraudster or for the purposes of other parties. This may for example be achieved by:

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

The following three categories of fraud are defined:

- **Internal fraud** – Fraud against the insurer by an employee, a manager or a board member on his/her own or in collusion with others who are either internal or external to the insurer.
- **Policyholder fraud and claims fraud** – Fraud against the insurer in the purchase and/or execution of an insurance product by obtaining wrongful coverage or payment.
- **Intermediary fraud** – Fraud by intermediaries against the insurer or policyholders. For the purpose of this questionnaire, “intermediary” should be understood to mean “independent broker/agent”.

Most of the respondents agreed with the definition or did not give comments. Some respondents noted that not every type of fraud was included in this definition, such as “third party fraud” (for example fraud by suppliers by overcharging) and fraud by the insurers against policyholders. In order to keep the guidance paper limited in size and complexity these types of fraud were not included in the guidance paper. Also for situations where an insurer is fraudulent, the IAIS has issued the *Guidance paper on combating the misuse of insurers for illicit purposes*.

After the definition, the survey questionnaire dealt with three different topics for each category of fraud:

- reasons for fraud risk management
- fraud risk indicators
- anti-fraud measures.

These topics were divided in two parts. Each topic started with closed questions, where the respondents could tick the importance of predefined options, on a scale from 1 to 6. These options contained the reasons, indicators and anti-fraud measures that were already incorporated in the draft guidance paper. The purpose of these questions was to validate, with experts in the insurance industry, the assumptions made in the draft guidance paper. Secondly, the respondents were given the opportunity to describe additional reasons, indicators or measures that were not mentioned in the guidance paper. The purpose of these open questions was to identify missing elements in the guidance paper. At the end, the

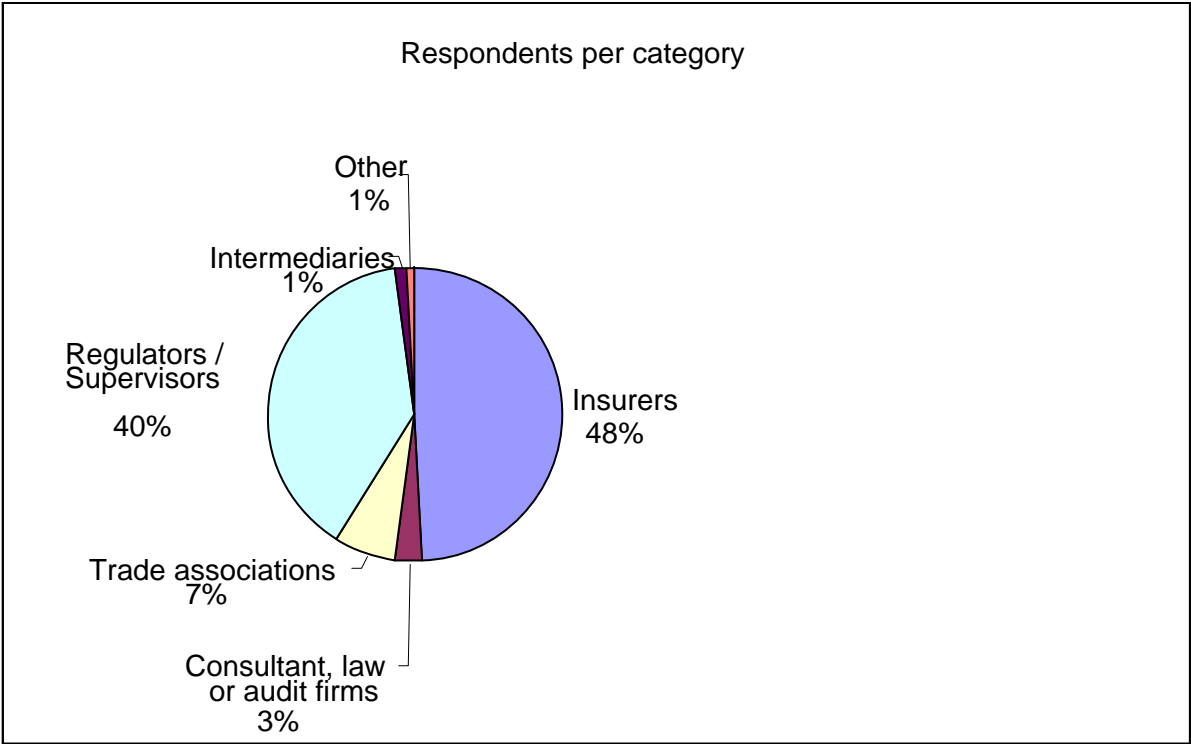
⁴ See Appendix 2 for the complete questionnaire

questionnaire contained open questions about the experience of the respondents and about the main problems in the battle against fraud.

4. Responses to the survey questionnaire

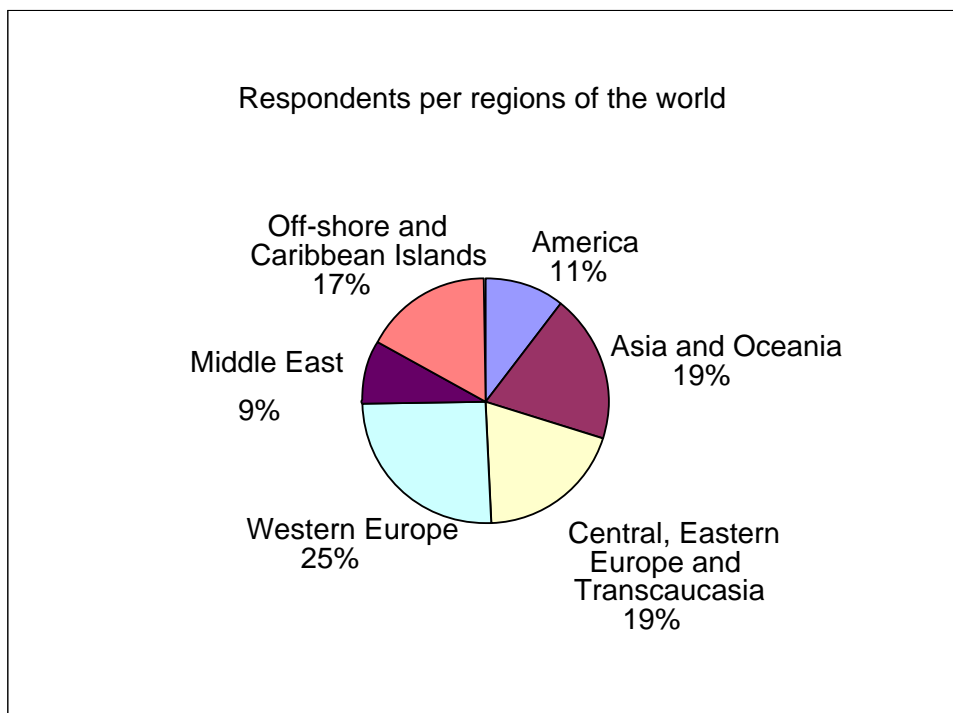
The IFS received 106 responses to the survey questionnaire of which 52 were completed by insurers, 7 by trade associations, 42 by supervisors and 5 by other organizations (see Graph 1). The insurers are active in different branches (property & casualty, healthcare, life, others) and use different distribution methods (direct writing, intermediaries or both).

Graph 1



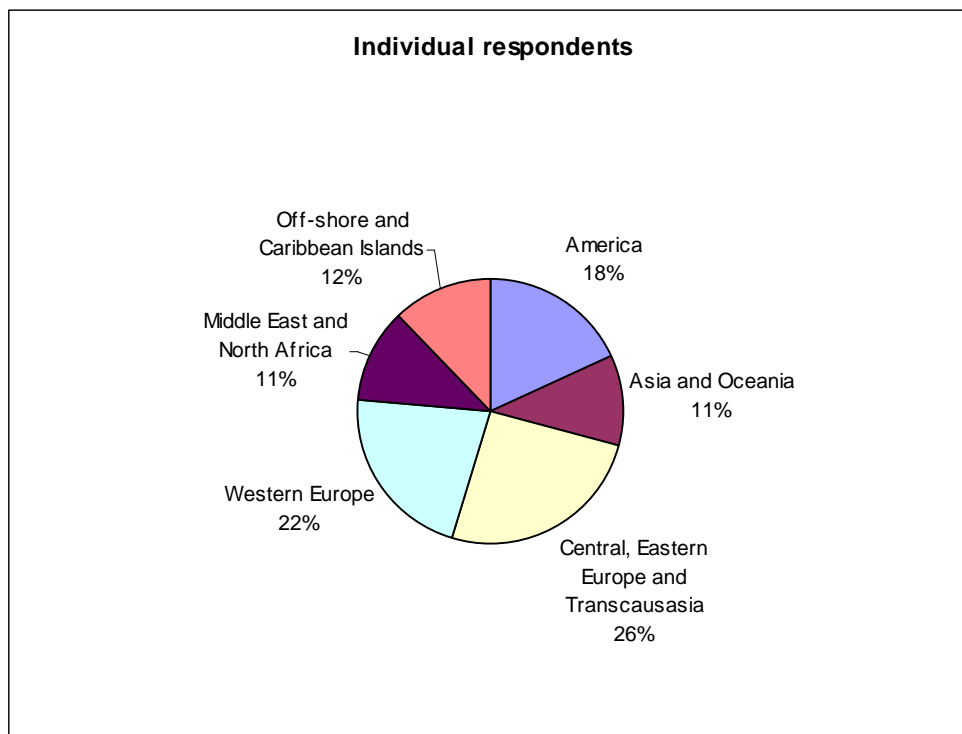
The respondents represented almost 50 countries or regions from all over the world, except Africa (see list in Appendix 1). Most of them are European (44%) and Asian (28%) countries and regions (see Graph 2). From many countries there were only one or two respondents, but from some countries many responses were received (for example: Turkey: 18, USA: 16, Jordan: 9, Spain 6).

Graph 2



When we look at the division of individual respondents, we see a somewhat different picture. From many countries there were only one or two respondents, but from some countries we received more responses (for example: Turkey: 18, USA: 16, Jordan: 9, Spain 6). This causes a shift in the division when we look at the level of the individual respondents. See Graph 3 for the result.

Graph 3



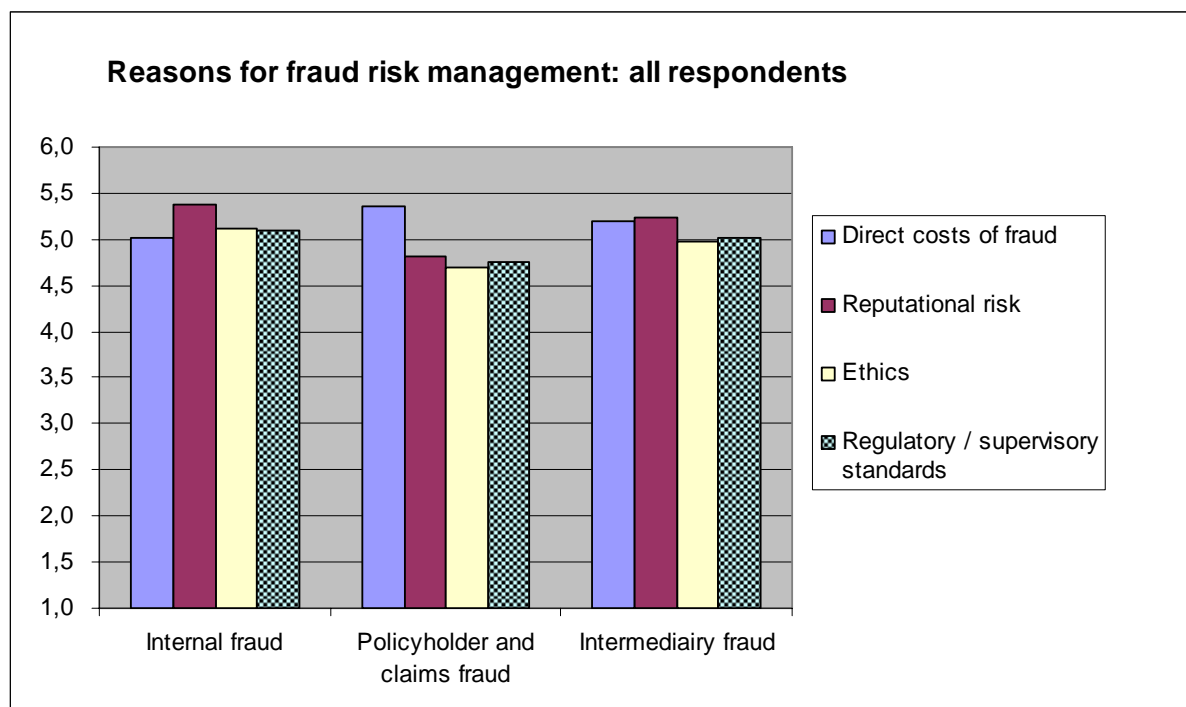
In the analysis, all individual responses are included on an equal basis. Some additional analysis was undertaken based on an “average opinion” for each country. In that way, the effect of the unequal division of respondents among the different countries was measured. This different approach did not cause relevant shifts in the results.

Most of the respondents completed all the close questions and many of them gave useful suggestions by answering the open questions.

5. Reasons for fraud risk management

The supervisors should have a clear opinion about the reasons why the insurance industry should manage fraud risk. Only then can they justify their attention on the issue in their supervisory activities. It is also interesting to know the reasons why the insurance industry wants to manage this risk: is this just because it is a supervisory requirement; is it because of the costs of fraud or maybe because of reputation risk or ethical reasons? As shown in Graph 4, there appeared to be a slight relationship between the answers and the type of fraud.

Graph 4

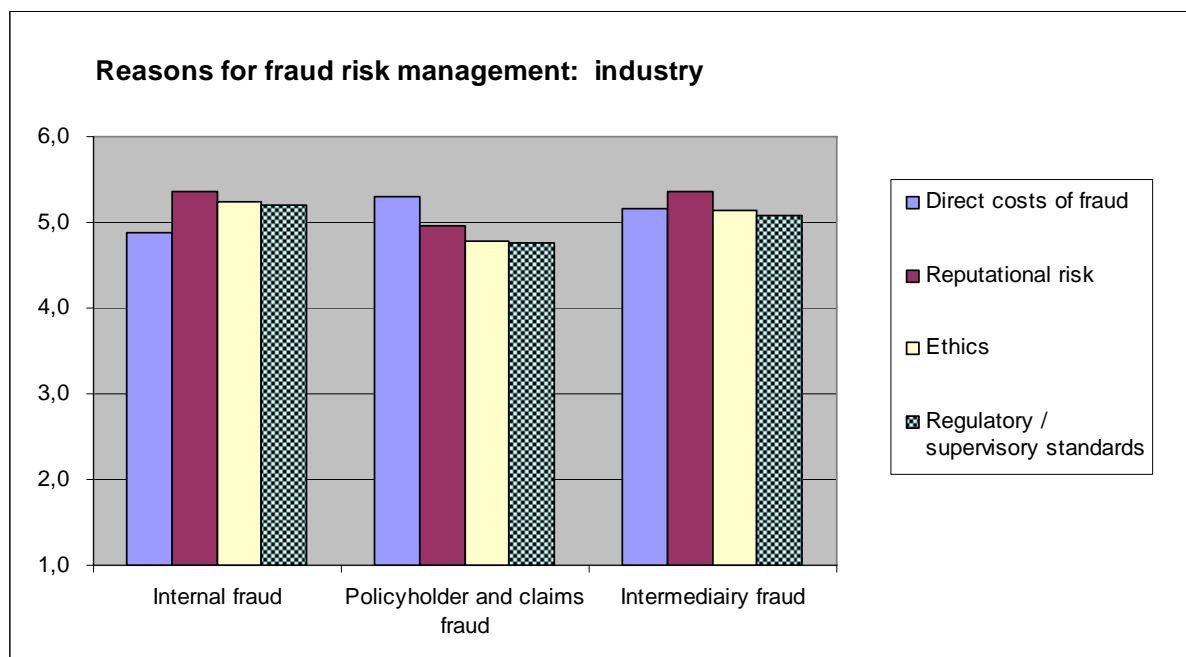


For policyholder and claims fraud, the direct costs of fraud are the most important reason to manage fraud risk. For intermediary fraud, the direct costs and the reputation risk are of almost equally importance. For internal fraud, the reputation risk is the most important reason. This may be because internal fraud (or indirectly related to the insurer) may have a larger effect on reputation than a fraud from the outside. A possible explanation may be that people do not want to give their money (premiums) to organisations where fraud is committed and where they feel that the fraudster steals their money. For policyholder and claims fraud, respondents seem to have a different opinion. One of the most frequently provided answer to the question about the biggest problems in the fight against fraud (see later discussion) was that policyholder and claims fraud is widely accepted among the public. It may be interpreted

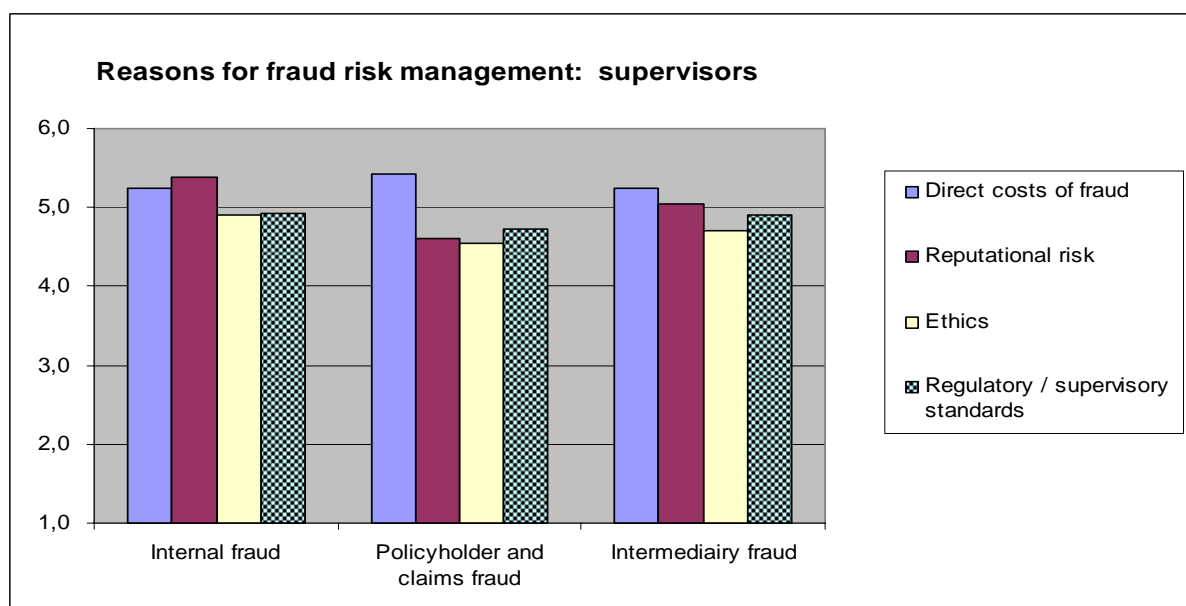
that people do not think it is very wrong to commit this type of fraud and do not see that premiums will go up because of fraud. Consequently, the reputation of an insurer will suffer more when internal or intermediary fraud is revealed than when policyholder and claims fraud is not managed properly.

It is interesting to consider whether the supervisors have a different opinion on the reasons for fraud risk management than the insurance industry (including responses from the insurers, the intermediaries and trade associations). Graphs 5 and 6 show that the differences are small. The only different order of importance can be found in the category of intermediary fraud; the industry thinks that the reputation risk is the most important reason, where the supervisors rate direct costs the highest.

Graph 5



Graph 6



In conclusion it can be said that all the reasons mentioned in the draft guidance paper and the survey questionnaire are thought to be important by the respondents. The supervisors do not only look at the immediate financial aspects, but also at integrity aspects. It is also important to conclude that the industry has a broad approach in managing fraud risk. Finally, it is good to get a confirmation that the opinions of the supervisors and the insurance industry are aligned.

The open question about reasons for fraud risk management provided some suggestions concerning organisational costs and values. Fraud may affect staff morale and staff turnover. These are indeed important topics. More generally, they can be categorised under reputation risk or ethics.

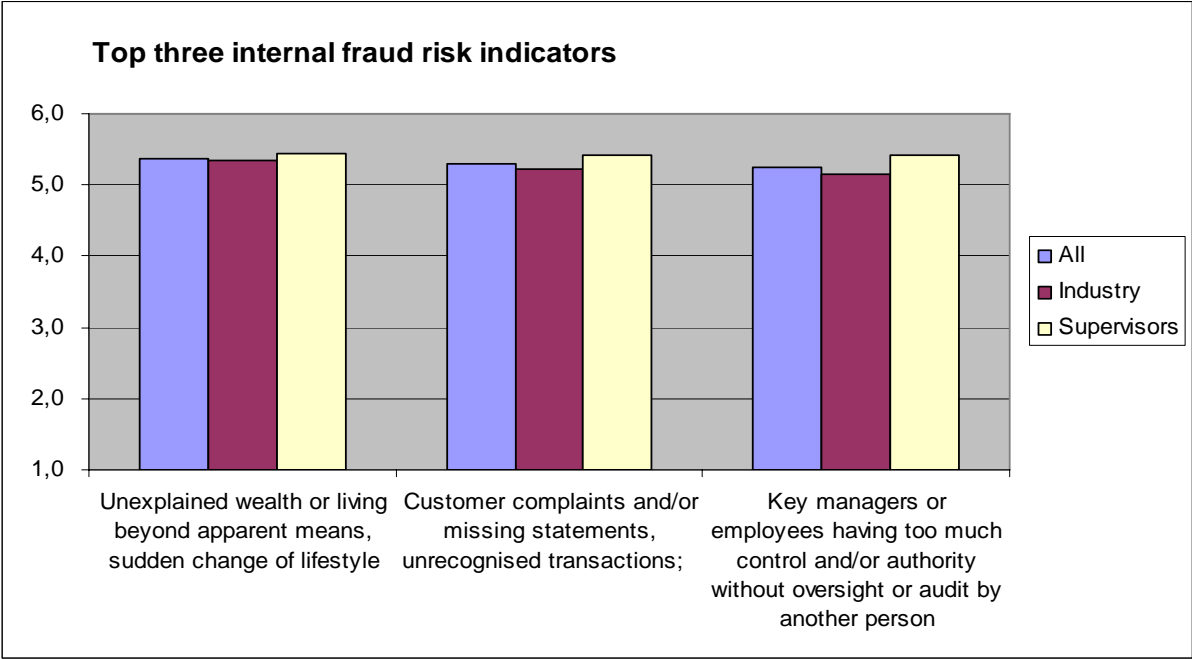
6. Fraud risk indicators⁵

To detect fraud, it is important to know what to look for. Therefore, respondents were asked about fraud risk indicators for the three fraud categories.

Internal fraud risk

Indicators of internal fraud risk can come from different sources, from inside or outside insurers. The top three rated fraud risk indicators show this diversity: managers of employees that behave differently, customers' complaints and flaws in the internal control structure (see Graph 7). Table 1 shows the average importance of all the internal fraud risk indicators. The conclusion is that it is important to consider the fraud risk from different points of view.

Graph 7



⁵ The existence of these fraud risk indicators does not mean that fraud has occurred or will occur. Nevertheless, insurers should be looking out for these fraud risk indicators, particularly when more than one occurs.

Table 1

Internal fraud risk (on a scale from 1 to 6)	All	Industry	Supervisors
Unexplained wealth or living beyond apparent means, sudden change of lifestyle	5,4	5,3	5,4
Customer complaints and/or missing statements, unrecognised transactions	5,3	5,2	5,4
Key managers or employees having too much control and/or authority without oversight or audit by another person	5,3	5,1	5,4
Rising costs with no explanation	4,9	4,8	5,1
Manager or employees with close or long-standing relationships with contractors	4,5	4,5	4,4
Manager or employees with external business interests	4,3	4,4	4,2
Marked personality changes of managers or employees	4,2	4,2	4,2
Fast increasing sales or change in product mix	4,0	4,0	4,1
Managers or employees who consistently work late, who are reluctant to take vacations and who seem to be under permanent stress	3,9	3,9	3,9
New managers or employees who resign quickly	3,7	3,5	4,1

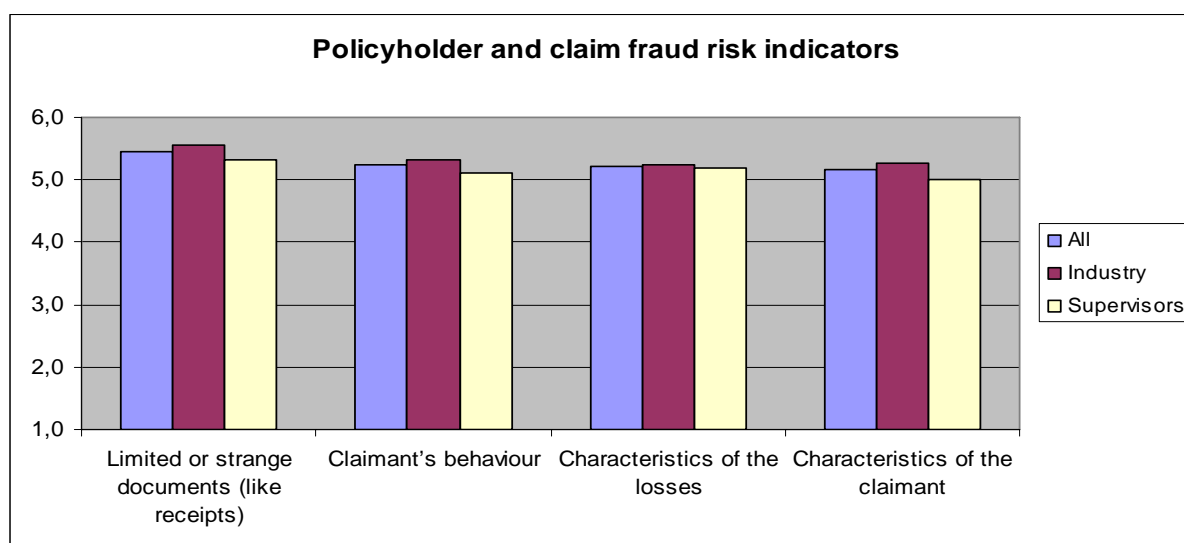
Respondents mentioned some other indicators in the open questions. Some were specific examples of the above-mentioned categories. New indicators that are more general are:

- Low staff morale without explanation.
- Inappropriate relationships exist at work or people act in an unusual manner (for example, evasive behaviour, unexplained curiosity of people over financial controls, etc.).
- Directors of the board and/or managers do not comply with laws and regulations and/or display a propensity to take undue risks
- 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 and/or managers do not provide satisfactory answers to the supervisor or auditor's questions or do not allow staff to speak to supervisors or auditors.
- Directors of the board and/or managers display a dominant management style that discourages critical or challenging views from others such as staff.
- 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)
- Poor accounting and/or poor documentation
- The organisational structure is changing and/or too complex.
- Directors of the board, managers or members of staff appear to exhibit extreme greed for personal gain.

Policyholder and claims fraud risk

For this category of fraud, each of the indicators mentioned in the survey was thought very important by the respondents (see Graph 8). There were no major differences between the industry and the supervisors. Only mentioned general warning signs and examples, independent of the product type. Per product type, indicators that are more specific can be determined⁶. The most important clue to detect insurance fraud is the documentation (like receipts, claim forms, application forms). Examples of warning signs are: no (original) documents are available, incomplete documents (no name on the documents or filled in later, no signature), different handwriting, new documents concerning old events/products, strange dates, inconsistencies between the application form and the claim form or too well documented claims (all receipts available, recent photographs of the items lost). An other important indicator is the claimant's behaviour: the claimant is aggressive, pushes for quick settlement, is willing to accept low settlement, is unwillingly to cooperate, avoids the use of telephone or mail, wants cash payment, did nothing to prevent or limit the damage, is very knowledgeable about the terms or has contacted the broker/agent or insurer immediately prior to the loss. In addition, the characteristics of the losses can give an indication of fraud: losses occur shortly after the coverage is inception or increased or just before it ceases or an inconsistency between the insured amount and the characteristics of the insured (like life style, age, profession). The last (but still important) group of indicators are the characteristics of the claimant, for example: the claimant's financial situation is bad, the claimant has a bad claim history or the claimant provides a post office box or hotel as address.

Graph 8



The different indicators show that it is important, but not sufficient, to pay attention to the claims and the losses. The claimant (his behaviour, his situation and the relation to the claimed losses) is a very important part of the puzzle. This has consequences for the systems to detect fraud: both the 'paper' claim assessment and the client contact function are essential in detecting fraud, as well as the interactions between the two.

The open questions gave some more indicators. Many were specifically linked to certain insurance products or could fit in the above-mentioned categories. They are included in the guidance paper. Three non-specific, newly mentioned indicators are:

- Insured frequently changes insurer.

⁶ See for a more detailed list the Guidance paper on preventing, detecting and remedying fraud in insurance

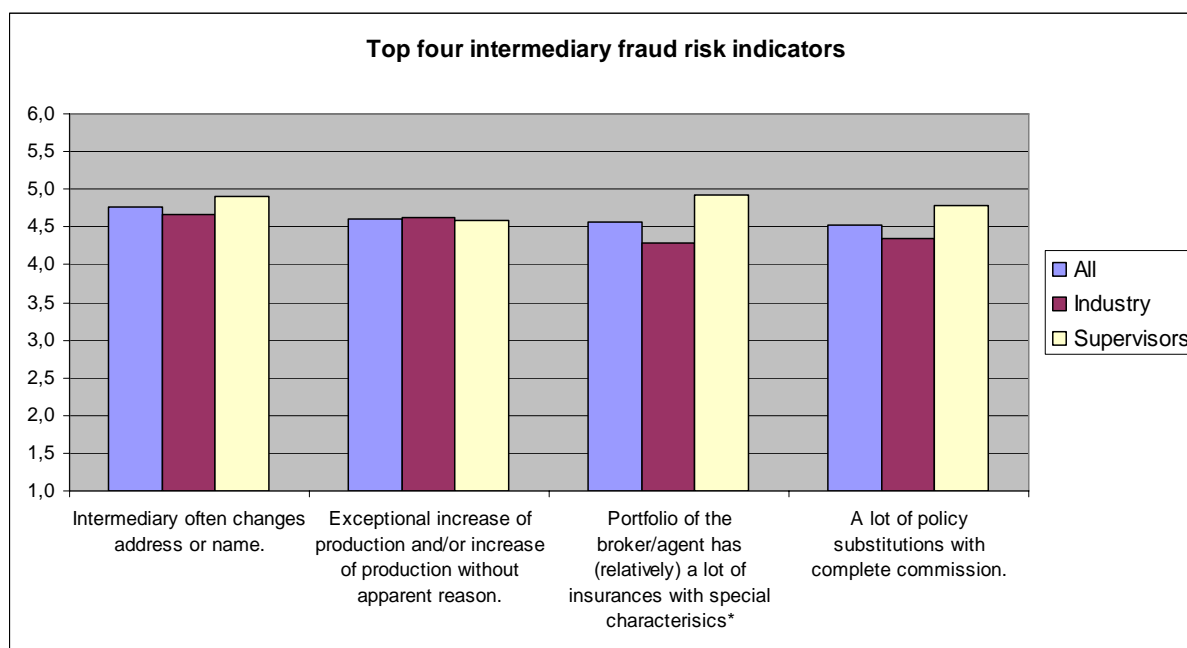
- Insured insists on using certain doctors, repair shops, service providers etc..
- Policyholder has several policies, with the same insured object and coverage, but did not inform the insurer.

Intermediary fraud risk

The average levels of importance for the risk indicators of intermediary fraud risk are a bit lower than the ones for the other two fraud categories. This may have a number of causes. Firstly, there are various ways in which intermediaries operate in the different jurisdictions (e.g. the use of cash payments or the commission scheme). A situation that provides a fraud indicator in a jurisdiction may be common in another. Secondly, intermediary fraud proves to be a difficult issue. Intermediaries sit in a position of trust between the purchasers of insurance and insurers. This trust forms a basic element of the relationship as the intermediary operates “at a distance”. Therefore, it may be difficult to find effective ways to handle the fraud risk.

The supervisors give higher scores than the insurance industry (see Graph 9). This is not necessarily because the industry thinks fraud risk management less important (see Graphs 5 and 6), but rather may be that the supervisors think more positively about the insurer’s possibilities to manage the relationship with the intermediaries. Table 2 shows the average importance of all the intermediary fraud risk indicators.

Graph 9



**Where the commission is higher than the first premium / with an arrears of premium payment / with a payment shortly after inception (life) / with unnatural maturities (after earning period of commissions).*

Table 2

Intermediary fraud (on a scale from 1 to 6)	All	Industry	Supervisors
Intermediary often changes address or name.	4,8	4,7	4,9
Exceptional increase of production and/or increase of production without apparent reason.	4,6	4,6	4,6
Portfolio of the broker/agent has (relatively) a lot of insurances with special characteristics*	4,6	4,3	4,9
A lot of policy substitutions with complete commission.	4,5	4,3	4,8
Insured and broker/agent are represented by the same person or have the same zip code;	4,1	3,9	4,5
Policyholder/insured lives beyond the region where the broker/agent operates. High insured amount by a broker/agent with a small portfolio.	4,1	4,0	4,2
Broker/agent asks for payment of all commissions at once or for payment of commissions in advance.	4,0	3,8	4,2
Request for payments to be made via the broker/agent	3,8	3,7	3,9

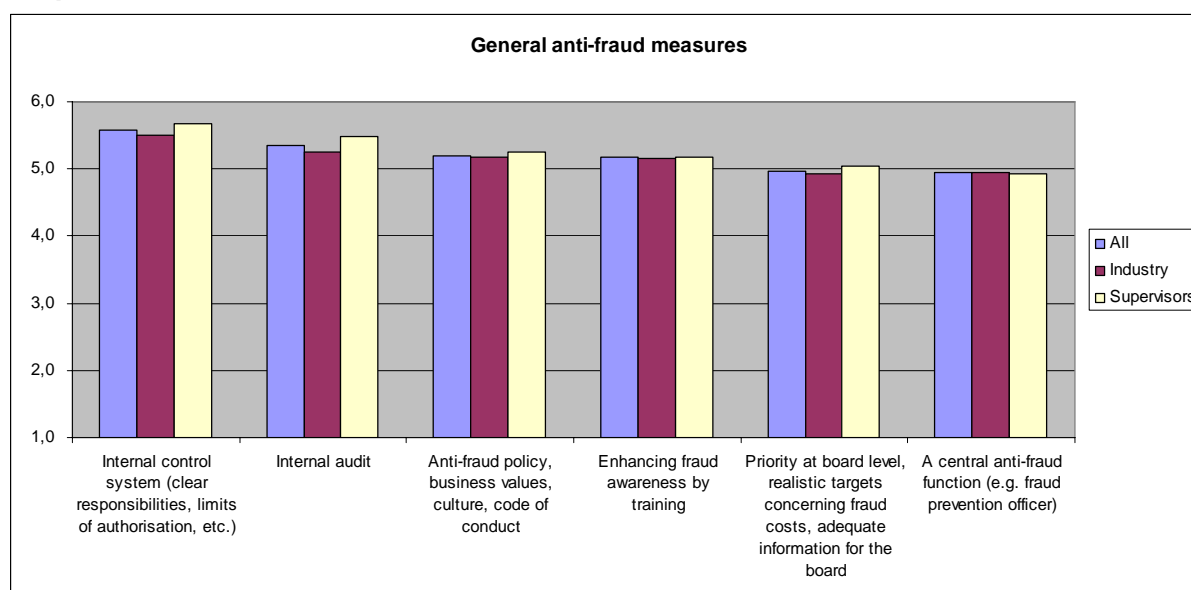
Answers on the open questions included:

- There is a high amount of claims fraud.
- There is a personal or other close relationship between the client and the intermediary.
- The premiums received and commissions paid are above or below the industry norm for the type of policy.
- There are frequent changes in control or ownership of the intermediary.
- There are a number of complaints or regulatory inquiries on the intermediary.
- The intermediary is in financial distress.
- The intermediary insists on using certain loss adjusters and/or contractors for repairs.
- The policyholder/insured lives outside the region where the intermediary operates.

7. Anti-fraud measures

In the survey questionnaire, a distinction was made between general and specific anti-fraud measures by fraud risk category. In the general category, internal control and internal audit were found the most important measures (see Graph 10). This is consistent with other surveys. Other more fraud specific measures that were indicated as important are: an anti-fraud policy, enhancing awareness, priority at board level and a central anti-fraud function. This indicates that it is essential to approach fraud in an integrated way; preventing and detecting internal, policyholder and claims fraud and intermediary fraud requires common and integrated views.

Graph 10



Many of the answers on the open question about general anti-fraud measures fall in one of the above-mentioned categories or belong to the more specific categories in the following paragraphs. Newly mentioned measures were about increasing cooperation, information sharing and enhancing public awareness.

Anti-fraud measures – internal fraud

When we look at specific measures to control the internal fraud risk, we see that internal control, internal audit and a fraud policy are still of big importance (see Graph 11). Table 3 shows the average importance of all the internal fraud risk indicators. New measures suggested are physical and procedural safeguards and elimination of potential conflict of interest. The only difference between the ratings of the industry and the supervisors is the higher importance that the supervisors give to the elimination of potential conflicts of interest.

Graph 11

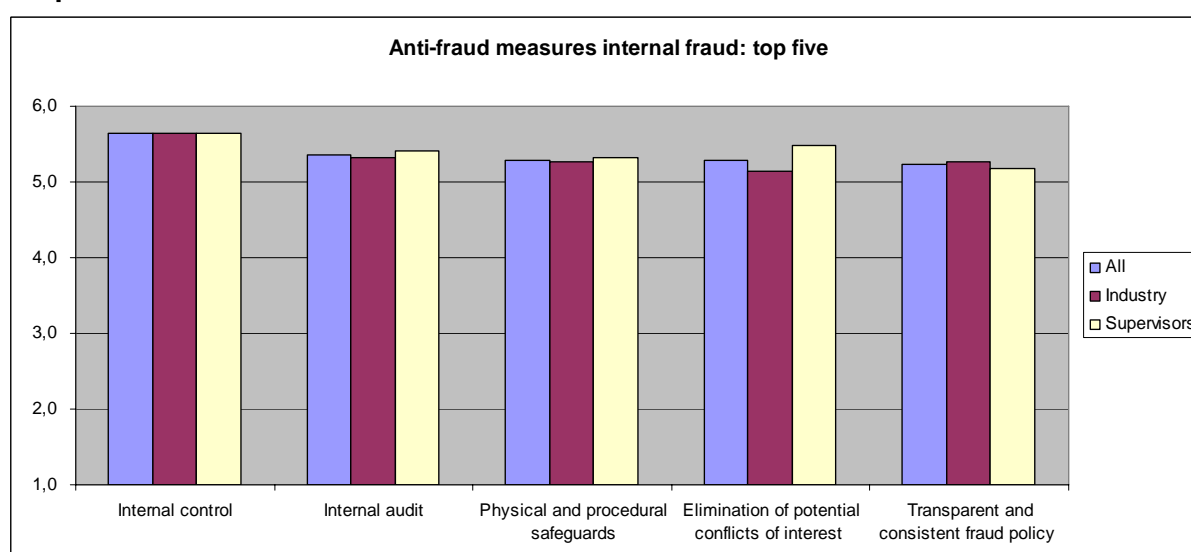


Table 3

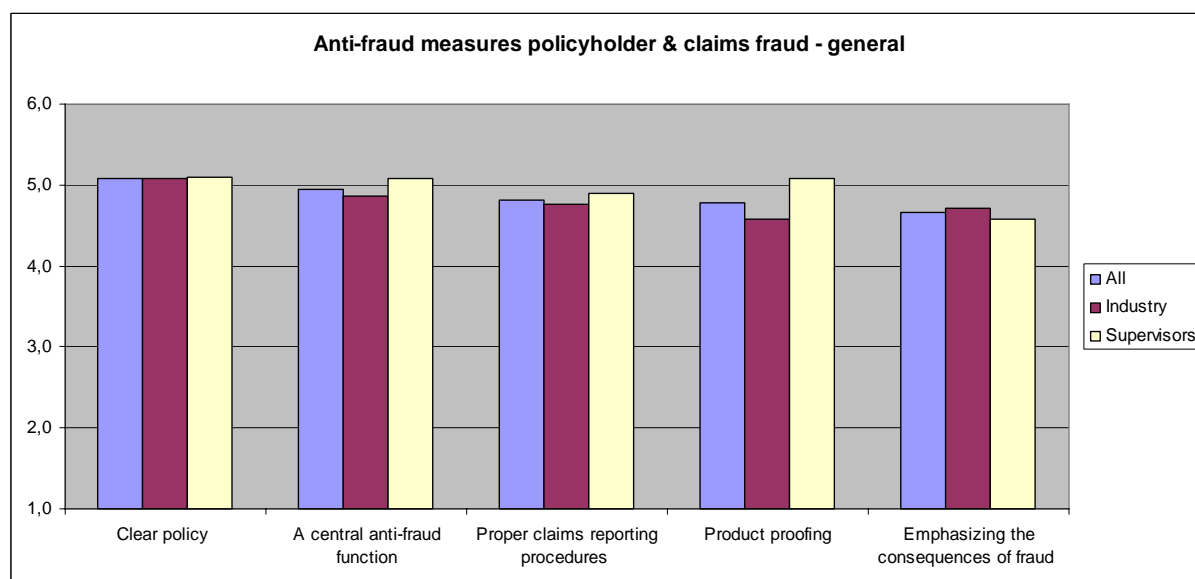
Anti-fraud measures internal fraud	All	Industry	Supervisors
Internal controls: establishment of clear responsibilities, elimination of the management of money flows by a single person, observance of the four-eyes principle (control by a second person), establishment of clear reporting lines and communication procedures.	5,6	5,6	5,6
Internal audit	5,4	5,3	5,4
Establishment of efficient physical and procedural safeguards over the use, handling and availability of cash, other assets and transactions as well as of information(systems).	5,3	5,3	5,3
Separation of any function that may cause conflict of interests; elimination of potential conflicts of interest between insurer, management and staff.	5,3	5,1	5,5
Establish a transparent and consistent policy in dealing with internal fraud (including a clear dismissal policy) no matter what management or staff grade.	5,2	5,3	5,2
Adequate supervision of staff and management	5,0	5,0	5,1
Whistle blowing procedures	4,9	5,0	4,8
Pre-employment screening of management and staff	4,8	4,8	4,9
A central anti-fraud function (e.g. fraud prevention officer)	4,8	4,7	5,0
Issuing an office manual and internal guidelines on ethical behaviour for management and staff.	4,6	4,5	4,7
In-employment screening of management and staff	4,5	4,4	4,6
Create an atmosphere that encourages social and emotional identification of management and staff with the insurer.	4,5	4,5	4,4
Mandatory vacations for staff and management in fraud sensitive positions	4,4	4,4	4,4

The answers on the open questions emphasise the fact that internal control, good awareness and culture are additional essential elements. Realistic business goals and a proper incentive structure were also judged important.

Anti-fraud measures – policyholder and claims fraud

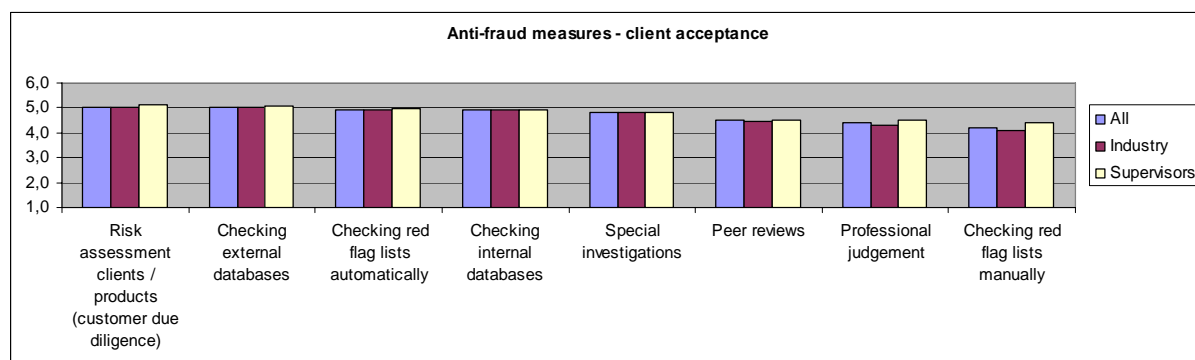
For policyholder and claims fraud, a distinction was made in general measures, client acceptance and claim assessment was made. The IFS also asked which information technology (IT) tools are important in fraud detection (see Graph 12). As for the general measures, again, the anti-fraud policy is very important, as well as the central anti-fraud function. These measures are immediately followed in importance by proper claims reporting procedures, product proofing (including designing fraud prevention characteristics when designing a product) and emphasising the consequences of fraud to the policyholders. The supervisors gave product proofing a higher score than the industry, which may indicate that the industry weighs the pros and cons differently, because of the commercial interests. However, this view is not conclusive - after all, the industry also gave a high score to product proofing.

Graph 12

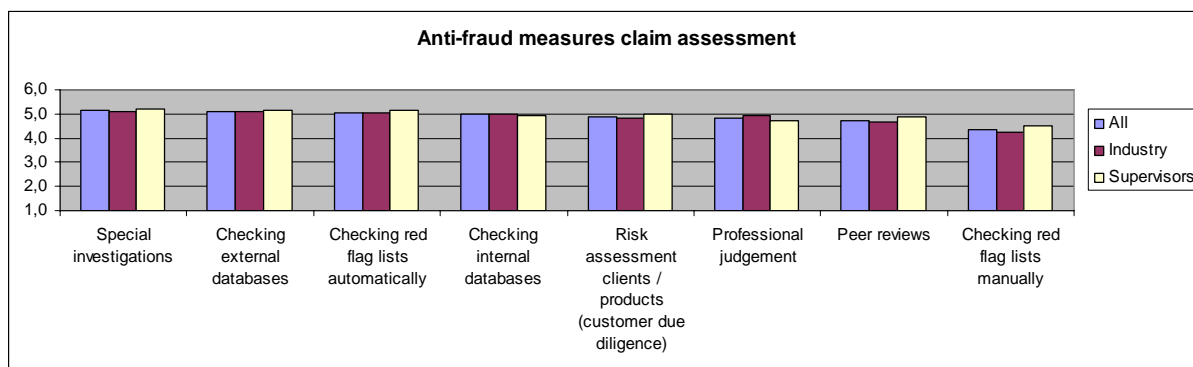


Graphs 13 and 14 present the specific measures for client acceptance and claim assessment. It is good to see that both preventative measures (client acceptance) and detection measures (claim assessment) are assessed as equally important by the respondents. In both cases, checking databases and red flag lists have high scores. It is clear that measures that make use of information technology are more important than the more traditional measures (peer reviews, professional judgement and checking red flag lists manually). Exceptions are special investigations and customer due diligence: the survey questionnaire did not make assumptions about the level of automation of these measures. However, as a conclusion it can be expected that IT will be integrated further into insurers' processes. Respondents gave their opinion about the importance of measures, but it does not mean that these measures are all implemented in practice.

Graph 13

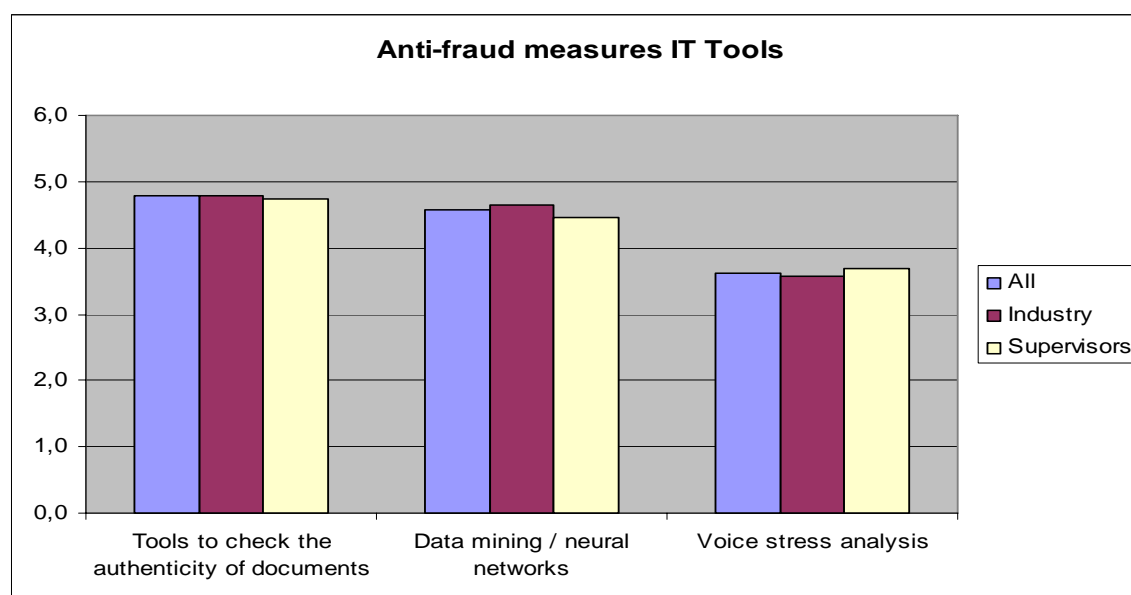


Graph 14



Because of the expected importance of specific IT tools in claim assessment, the respondents were asked about the importance of three different tools. Graph 15 shows the result. The specific tools are assessed as less important than the more general IT-supported measures (checking databases and red flag lists), but they still received high scores. Voice stress analysis has the lowest score, maybe because some respondents doubt the effectiveness or because of privacy concerns.

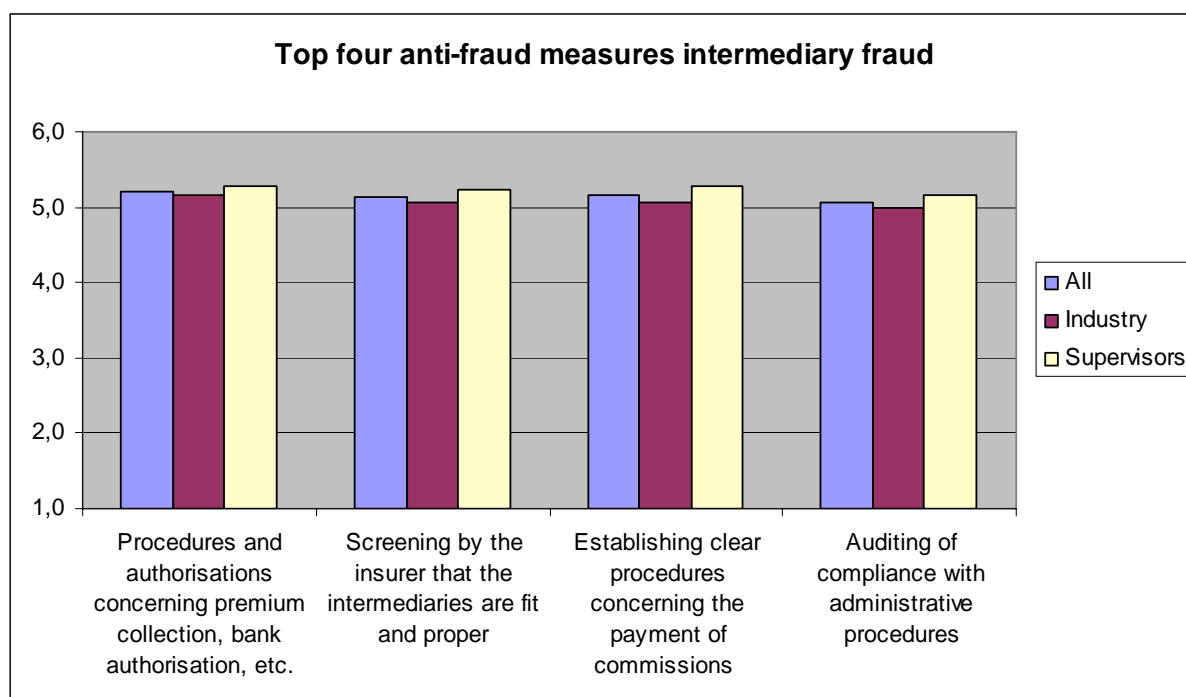
Graph 15



The answers on the open questions about anti-fraud measures for addressing policyholder and claims fraud show that training and information sharing between insurers, between insurers and law enforcement and between insurers and other parts of the chain (e.g. medical service providers, repair shops) are crucial.

Anti-fraud measures – intermediary fraud

To prevent and detect intermediary fraud, clear procedures and authorisations are crucial. These procedures should guarantee a proper premium collection, screening, payment of commissions and auditing of the intermediary. Graph 16 presents the top four measures and Table 4 shows the average importance of all the measures mentioned in the survey questionnaire.

Graph 16**Table 4**

Anti-fraud measures intermediary fraud	All	Industry	Supervisors
Procedures and authorisations concerning premium collection, bank authorisation, etc.	5,2	5,2	5,3
Screening by the insurer that the intermediaries are fit and proper	5,1	5,1	5,2
Establishing clear procedures concerning the payment of commissions, e.g. not paying any commission before the payment of the first premium, separation of funding intermediaries (to start up) and payment of commissions.	5,2	5,1	5,3
Auditing of compliance with administrative procedures	5,1	5,0	5,2
Monitoring the performance of intermediary relationships (quality of business, anticipated and actual levels, persistency of business)	5,0	5,0	4,9
Establishing a complaints procedure and monitoring of complaints	5,0	4,9	5,0
Disclosure procedures about the intermediaries and their organisation	4,8	4,9	4,7
A central anti-fraud function (e.g. fraud prevention officer)	4,8	4,7	4,9
Instructing intermediaries not to accept payment in cash	4,7	4,7	4,7
The establishment of procedures to send policies and renewal documents directly to the policyholder	4,7	4,7	4,7

The open question about intermediary fraud stresses the importance of “Know Your Intermediary”: communication, training and auditing. A new element that is mentioned is the need for a direct contact with the policyholder. In addition, knowledge sharing between insurers is mentioned.

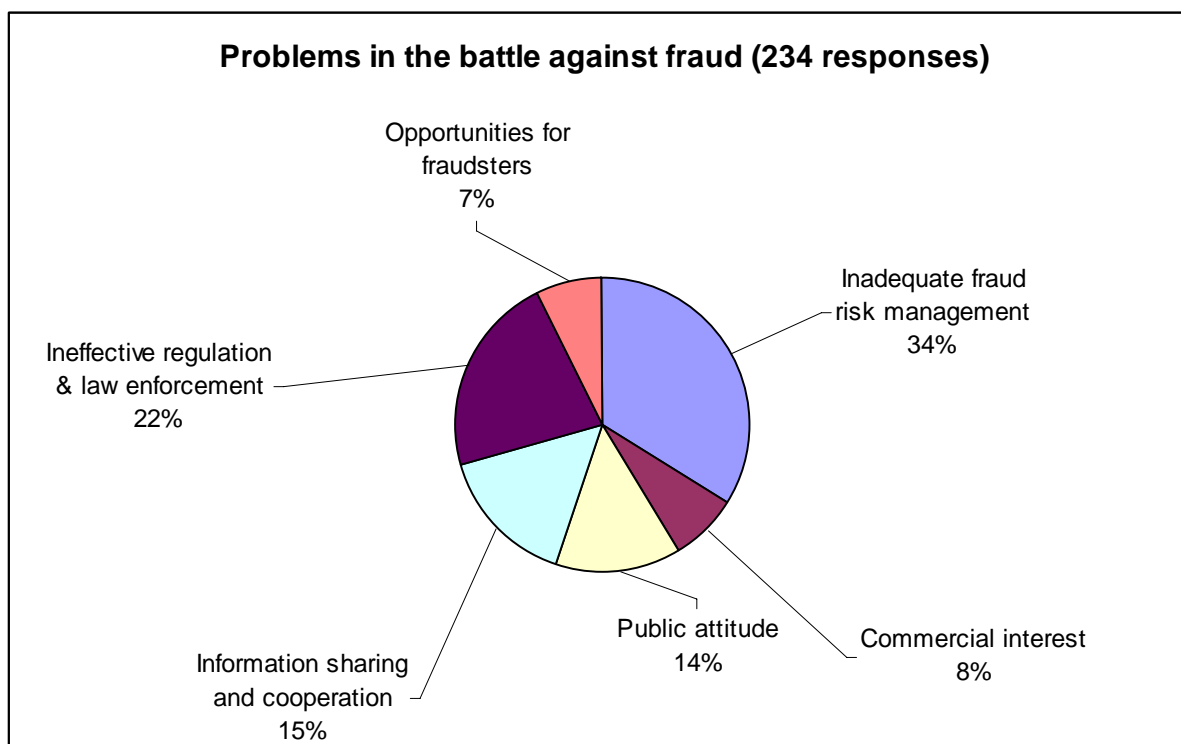
8. Problems in the battle against fraud

The last question of the survey was an open question to provide an insight into what the industry perceives as the biggest difficulties in preventing, detecting and remedying fraud. Apparently, this was a popular question; with respondents providing an overwhelming list of issues (234 problems were mentioned). The responses can be ordered in six categories:

- Inadequate fraud risk management (79): this category deals with all different aspects of the fraud risk's management system. Examples of problems are: no priority at board level, no effective anti-fraud policy, lack of knowledge and training, lack of fraud awareness, an improper organisational culture, an inadequate internal control system and lack of internal audit.
- Commercial interest (18): this category represents the issue that the cost-benefit analysis of anti-fraud measures is not always, at least not in the short term, in favour of fraud prevention and detection. On a case-by-case basis, fraud detection is expensive compared to the direct costs of the fraud. Also efficient claim settlement is good for customer service, but may hamper fraud detection. In relation to intermediaries, insurers may not want to make things hard for intermediaries because of competition.
- Public attitude (32): concerning “opportunity” fraud, public attitude does not help to combat fraud. Many people see fraud as a victimless crime. They commit fraud without feeling that they have done anything wrong. In their opinion, “insurers have deep pockets” and it is only fair to compensate for long years of premium payment by committing fraud. They do not realize that fraud will lead to higher premiums and that their attitude may cause an upward spiral of fraud and premiums.
- Information sharing and cooperation (36): In this category, the lack of cooperation between insurers themselves, between insurers and law enforcement and between supervisors and law enforcement internationally is addressed.
- Ineffective regulation and law enforcement (52): an often-heard complaint is that law enforcement has too little capacity or that no priority is given to insurance fraud. In addition, it is difficult to prove fraud, and privacy and market regulation may hamper fraud detection.
- Opportunities for fraudsters (17): this last category deals with the fact that due to inherent characteristics of insurance products (trust based) and due to the increasing use and possibilities of information technology, fraud is difficult to detect and to prove. Schemes are complex and sophisticated.

Graph 17 shows the segmentation of all the responses in the above-mentioned categories.

Graph 17

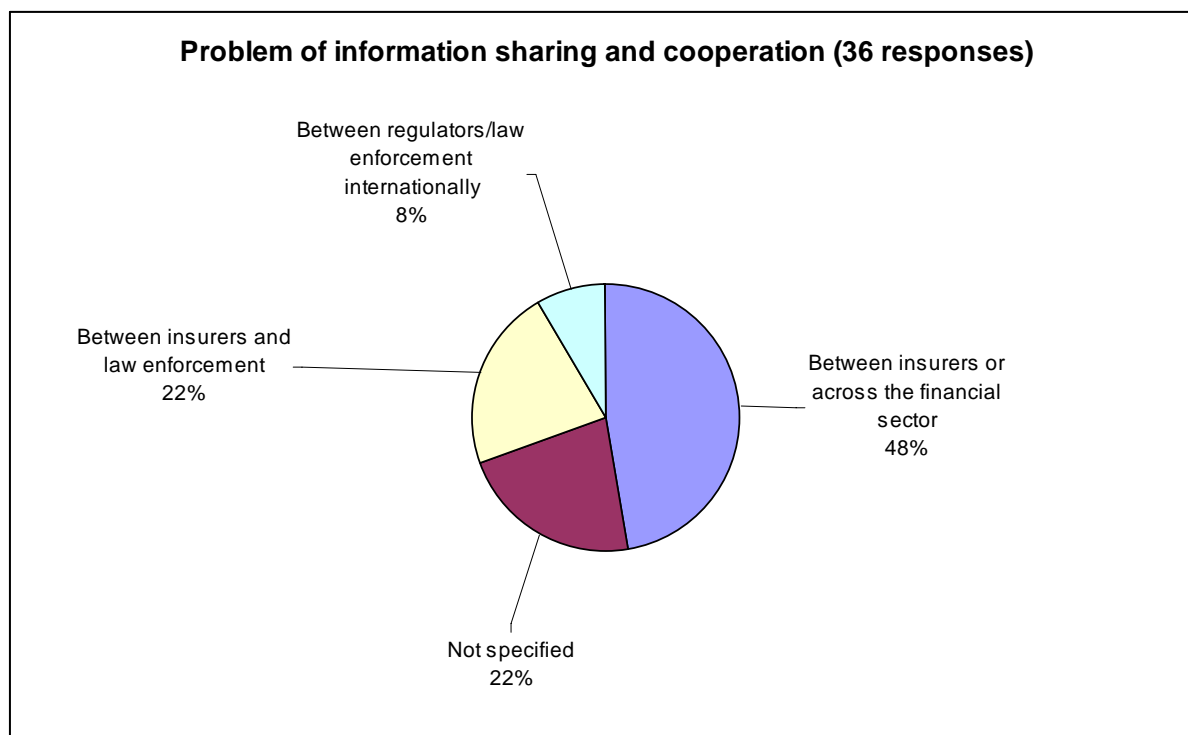


When the responses from the insurance industry (148 responses) and the supervisors (86 responses) are considered separately, the picture does not change dramatically. The industry mentioned more often an ineffective regulation and enforcement (27% by the industry against 14% by the supervisors), where the supervisors were more critical about the fraud risk management function of insurers (30% by industry against 41% by the supervisors). However, these differences do not really change the proportions between the different categories.

It is interesting to consider that a part of the spectrum of problems is within the reach of the insurers and the supervisors: inadequate fraud risk management can be directly addressed by insurers and more indirectly by the supervisors. It is also a choice of insurers to let commercial interests prevail over fraud prevention; cooperation between insurers may help to ensure that competitive concerns do not hamper the battle against fraud. Insurers also can cooperate to influence public attitude to insurance fraud.

In respect of other problem area, however, insurers cannot solve the issues alone. Information sharing and cooperation is crucial, not only to detect fraud, but also to influence public attitude. Graph 18 gives a closer look at the problem of information sharing and cooperation.

Graph 18



Apparently, the biggest problem in this category concerns the information sharing and cooperation between the insurers. Again, there are some differences in the responses from industry and the supervisors: industry mentions more often the cooperation between insurers (52% by industry against 36% by the supervisors); the supervisors have more answers that are not specified. The conclusion is that insurers can do a lot by cooperation, but also that they need law enforcement to combat fraud effectively. This conclusion is enforced by the fact that 22% of the mentioned problems are related to ineffective regulation or law enforcement.

The only category where it is very difficult to make changes is the category “opportunities for fraudsters”. The problems that were mentioned are inherent to insurance products or to the developments in organised crime or information technology. However, the effects of these characteristics can be minimised by improvements in the other areas. Fraud occurs when there is a combination of opportunity, rationalisation and incentive. Through adequate risk management, cooperation, law enforcement and influencing public attitude, important advances can be made in the battle against fraud.

APPENDIX I – List of countries and regions or respondents

Country or region	Number of responses	Country or region	Number of responses
Australia, New Zealand and Asia	1	Korea	1
Belgium	1	Latvia	1
Belize	3	Lithuania	1
Brazil	1	Macau	1
British Virgin Islands	1	Malaysia	1
Canada	1	Netherlands (the)	2
Cayman Islands	1	Philippines	1
Chinese Taipei	1	Poland	1
Czech Republic	1	Portugal	1
El Salvador	1	Qatar	1
Europe	1	Romania	2
Finland	1	Saudi Arabia	1
Germany	2	Singapore	2
Guernsey	1	Slovakia	1
Hong Kong	1	Spain	6
Iceland	1	Sweden	2
Isle of Man	2	Switzerland	1
Israel	1	Trinidad and Tobago	1
Italy	1	Turkey	18
Jamaica	3	United Kingdom	4
Japan	3	Ukraine	1
Jersey	1	United Arab Emirates	1
Jordan	8	USA	15
Jordan, Qatar, Palestine	1	USA & Canada	1
		Total	106

PREVENTING, DETECTING AND REMEDYING FRAUD IN INSURANCE



QUESTIONNAIRE

WORKING GROUP OF THE INSURANCE FRAUD SUBCOMMITTEE OF THE INTERNATIONAL ASSOCIATION OF INSURANCE SUPERVISORS

Introduction

The International Association of Insurance Supervisors (IAIS) gives fraud prevention high priority. To provide guidance for insurers, intermediaries and supervisors so that the potential risk of fraud in the insurance sector can be identified and reduced as much as possible, the Insurance Fraud Subcommittee is preparing a Guidance Paper on preventing, detecting and remedying fraud in insurance.

The Insurance Fraud Subcommittee would like to take advantage of the knowledge and experience of the experts in the insurance sector. With this questionnaire we want to collect the views of the participants of the IAIFA meeting on best practices, red flags, etc. The results of the survey will assist in drafting the Guidance Paper. Results of the survey will also be presented at the IAIFA meeting in June 2006.

This questionnaire can also be found at the IAIFA website: www.iaifa.org

Please submit your replies as indicated at the end of the questionnaire before the close of business on June 9th 2006

Most of the questions can be answered by choosing the most applicable answer. If you fill in the questionnaire on paper, you can just circle the answer of your choice. If you fill in the questionnaire electronically, it may be best to just mark the chosen option by underlining the text (select the text and Ctrl-U) or making the text bold (select the text and Ctrl-B).

1. General questions	
Type of company you work for ⁷	Consultant & Regulatory under contract
Your position in this company	Owner
Jurisdiction of the company	Florida / USA
Lines of business of the company ⁸	Life / Property and casualty
Distribution method ²	both

Definition of fraud

For the purposes of this questionnaire fraud in insurance is defined as follows. An activity is fraudulent (hereafter referred to as fraud) if it is intended to gain dishonest advantage for the fraudster or for the purposes of other parties. This may for example be achieved by:

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

⁷ E.g. insurance company, supervisor, regulator, law enforcement institute, consultancy firm, trade association

⁸ If applicable

The following three categories of fraud are defined:

- **Internal fraud** – Fraud against the insurer by an employee, a manager or a board member on his/her own or in collusion with others who are either internal or external to the insurer.
- **Policyholder fraud and claims fraud** – Fraud against the insurer in the purchase and/or execution of an insurance product by obtaining wrongful coverage or payment.
- **Intermediary fraud** – Fraud by intermediaries against the insurer or policyholders. For the purpose of this questionnaire “intermediary” should be understood to mean “independent broker/agent”.

Please include any comments you may have with respect to the above definition(s) of fraud:

Reasons for fraud risk management

2. What level of importance would you assess to the following reasons for insurance companies for managing internal fraud risk?

	Not importantvery important						No opinion
Direct costs of fraud	1	2	3	4	5	6	?
Reputational risk	1	2	3	4	5	6	?
Ethics	1	2	3	4	5	6	?
Regulatory/supervisory standards	1	2	3	4	5	6	?
Other, namely	1	2	3	4	5	6	?

3. What level of importance would you assess to the following reasons for insurance companies for managing policyholder and claims fraud risk?

	Not importantvery important						No opinion
Direct costs of fraud	1	2	3	4	5	6	?
Reputational risk	1	2	3	4	5	6	?
Ethics	1	2	3	4	5	6	?
Regulatory/supervisory standards	1	2	3	4	5	6	?

Other, namely	1	2	3	4	5	6	?
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4. What level of importance would you assess to the following reasons for insurance companies for managing intermediary fraud risk?

	Not importantvery important						No opinion
Direct costs of fraud	1	2	3	4	5	6	?
Reputational risk	1	2	3	4	5	6	?
Ethics	1	2	3	4	5	6	?
Regulatory/supervisory standards	1	2	3	4	5	6	?
Other, namely	1	2	3	4	5	6	?

Fraud risk indicators

5. In your opinion, what is the importance of the following indicators of internal fraud risk?

	Not importantvery important						No opinion
Managers or employees who consistently work late, who reluctant to take vacations and who seem to be under permanent stress	1	2	3	4	5	6	?
New managers or employees resigning quickly	1	2	3	4	5	6	?
Marked personality changes of managers or employees	1	2	3	4	5	6	?
Unexplained wealth or living beyond apparent means, sudden change of lifestyle	1	2	3	4	5	6	?
Key managers or employees having too much control and/or authority without oversight or audit by another person	1	2	3	4	5	6	?
Manager or employees with external business interests	1	2	3	4	5	6	?
Manager or employees with close or long – standing relationships with contractors	1	2	3	4	5	6	?
Customer complaints and/or missing statements, unrecognised transactions;	1	2	3	4	5	6	?
Rising costs with no explanation	1	2	3	4	5	6	?
Fast increasing sales or change in	1	2	3	4	5	6	?

product mix							
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<p>What other indicators or red flags concerning internal fraud risk can you mention?</p> <p>1.</p> <p>2.</p> <p>3.</p> <p>Please also mark the importance (1 to 6 or “?”)</p>
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6. In your opinion, what is the importance of the following indicators of policyholder and claims fraud risk?

	Not importantvery important						No opinion
Claimant's behaviour: claimant is aggressive, pushes for quick settlement, is willing to accept low settlement, is unwillingly to cooperate, avoids the use of telephone or mail, wants cash payment, did nothing to prevent or limit the damage, is very knowledgeable about the terms, has contacted the broker/agent or insurer immediately prior to the loss.	1	2	3	4	5	6	?
Limited or strange documents (like receipts): no (original) documents, no name on the documents (or filled in later), different handwriting, new documents concerning old events/products, strange dates, inconsistencies between the application form and the claim form or too well documented claims (all receipts available, recent photographs of the items lost).	1	2	3	4	5	6	?
Characteristics of the losses: losses occur shortly after the coverage is inception or increased or just before it ceases, inconsistency between the insured amount and the characteristics of the insured (like life style, age, profession).	1	2	3	4	5	6	?
Characteristics of the claimant: the	1	2	3	4	5	6	?

claimant's financial situation is bad, bad claim history, claimant provides a post office box or hotel as address.							
--	--	--	--	--	--	--	--

What other indicators or red flags concerning policyholder and claims fraud risk can you mention?
1.
2.
3.

In your opinion, what is the importance of the following indicators of intermediary fraud risk?

	Not importantvery important						No opinion
Broker/agent asks for payment of all commissions at once or for payment of provisions in advance.	1	2	3	4	5	6	?
Policyholder/insured lives beyond the region where the broker/agent operates High insured amount by a broker/agent with a small portfolio.	1	2	3	4	5	6	?
Request for payments and or via the broker/agent correspondence.	1	2	3	4	5	6	?
Insured and broker/agent are represented by the same person or have the same zip code;	1	2	3	4	5	6	?
Request for payments and or via the broker/agent correspondence.	1	2	3	4	5	6	?
Portfolio of the broker/agent has (relatively) a lot of insurances: <ul style="list-style-type: none"> • where the provision is higher than the first premium; • with an arrears of premium payment; • with a payment shortly after inception (life); • with unnatural maturities (after earning period of provisions). 	1	2	3	4	5	6	?
Exceptional increase of production and/or increase of production without apparent reason.	1	2	3	4	5	6	?
A lot of policy substitutions with	1	2	3	4	5	6	?

complete commission.							
Intermediary often changes address or name.	1	2	3	4	5	6	?

What other indicators or red flags concerning intermediary fraud risk can you mention?
1.
2.
3.
Please also mark the importance (1 to 6 or “?”)

Anti-fraud measures

In the way that insurance companies and intermediaries deal with fraud risk, a distinction can be made in measures that are directed at fraud risk in general and measures that are specifically directed at internal fraud risk or at policyholder and claim fraud risk or intermediary fraud risk. In the following three tables this distinction is made as well.

8. In your opinion, what measures are the most effective in the battle against fraud in general?

	Not importantvery important						No opinion
Anti-fraud policy, business values, culture, code of conduct	1	2	3	4	5	6	?
Priority at board level, realistic targets concerning fraud costs, adequate information for the board	1	2	3	4	5	6	?
A central anti-fraud function (e.g. fraud prevention officer)	1	2	3	4	5	6	?
Enhancing fraud awareness by training	1	2	3	4	5	6	?
Internal control system (clear responsibilities, limits of authorisation, etc.)	1	2	3	4	5	6	?
Internal audit	1	2	3	4	5	6	?

What other measures or procedures can you mention concerning fraud risk in general?
1.
2.

3.

Please also mark the importance (1 to 6 or "?")

9. What measures are in your opinion the most effective in the battle against internal fraud?

	Not importantvery important						No opinion
Issuing an office manual and internal guidelines on ethical behaviour for management and staff	1	2	3	4	5	6	?
Create an atmosphere that encourages social and emotional identification of management and staff with the insurer	1	2	3	4	5	6	?
A central anti-fraud function (e.g. fraud prevention officer)	1	2	3	4	5	6	?
Internal controls: establishment of clear responsibilities, elimination of the management of money flows by a single person, observance of the four-eyes principle (control by a second person), establishment of clear reporting lines and communication procedures	1	2	3	4	5	6	?
Adequate supervision of staff and management	1	2	3	4	5	6	?
Establishment of efficient physical and procedural safeguards over the use, handling and availability of cash, other assets and transactions as well as of information(systems)	1	2	3	4	5	6	?
Separation of any function that may cause conflict of interests; elimination of potential conflicts of interest between insurer, management and staff	1	2	3	4	5	6	?
Pre-employment screening of management and staff	1	2	3	4	5	6	?
In-employment screening of management and staff	1	2	3	4	5	6	
Mandatory vacations for staff and management in fraud sensitive positions	1	2	3	4	5	6	?
Establish a transparent and consistent policy in dealing with internal fraud (including a clear dismissal policy) no	1	2	3	4	5	6	?

matter what management or staff grade							
Whistle blowing procedures	1	2	3	4	5	6	?
Internal audit	1	2	3	4	5	6	?

<p>What other measures or procedures can you mention concerning internal fraud risk?</p> <p>1.</p> <p>2.</p> <p>3.</p> <p>Please also mark the importance (1 to 6 or “?”)</p>

10. What measures are in your opinion the most effective in the battle against policyholder and claims fraud?

	Not importantvery important						No opinion
A clear policy concerning fraud management	1	2	3	4	5	6	?
A central anti-fraud function (e.g. fraud prevention officer)	1	2	3	4	5	6	?
Product proofing (including fraud preventing characteristics when designing a product e.g. by reimbursing only the actual value of property and not the replacement value)	1	2	3	4	5	6	?
Emphasizing the consequences of fraud to the policyholder and claimant in the application form and in the contract	1	2	3	4	5	6	?
Establishing proper claims reporting procedures (such as clear forms, availability to answer questions)	1	2	3	4	5	6	?
<u>Client acceptance via</u>							
professional judgement	1	2	3	4	5	6	?
checking red flag lists manually	1	2	3	4	5	6	?
checking red flag lists automatically	1	2	3	4	5	6	?
peer reviews	1	2	3	4	5	6	?
checking internal databases	1	2	3	4	5	6	?

checking external databases	1	2	3	4	5	6	?
special investigations	1	2	3	4	5	6	?
risk assessment of clients and product combinations (customer due diligence / know your client)	1	2	3	4	5	6	?
other, namely	1	2	3	4	5	6	?
<u>Claim assessment via</u>							
professional judgement	1	2	3	4	5	6	?
checking red flag lists manually	1	2	3	4	5	6	?
checking red flag lists automatically	1	2	3	4	5	6	?
peer reviews	1	2	3	4	5	6	?
checking internal databases	1	2	3	4	5	6	?
checking external databases	1	2	3	4	5	6	?
special investigations	1	2	3	4	5	6	?
risk assessment of clients/ product/claim behaviour combinations	1	2	3	4	5	6	?
other, namely	1	2	3	4	5	6	?
IT-tools, such as:							
voice stress analysis	1	2	3	4	5	6	?
data mining / neural networks	1	2	3	4	5	6	?
tools to check the authenticity of documents	1	2	3	4	5	6	?
other, namely:	1	2	3	4	5	6	?

What other measures or procedures can you mention concerning policyholder and claims fraud risk?

1.

2.

3.

Please also mark the importance (1 to 6 or “?”)

11. What measures are in your opinion the most effective in the battle against intermediary fraud?

	Not importantvery important						No opinion
A central anti-fraud function (e.g. fraud prevention officer)	1	2	3	4	5	6	?
The establishment of procedures to send policies and renewal documents directly to the policyholder	1	2	3	4	5	6	?
Instructing intermediaries not to accept payment in cash	1	2	3	4	5	6	?
Procedures and authorisations concerning premium collection, bank authorisation, etc.	1	2	3	4	5	6	?
Screening by the insurer that the intermediaries are fit and proper	1	2	3	4	5	6	
Disclosure procedures about the intermediaries and their organisation	1	2	3	4	5	6	
Monitoring the performance of intermediary relationships (quality of business, anticipated and actual levels, persistency of business)	1	2	3	4	5	6	?
Auditing of compliance with administrative procedures	1	2	3	4	5	6	?
Establishing a complaints procedure and monitoring of complaints	1	2	3	4	5	6	?
Establishing clear procedures concerning the payment of provisions, e.g. not paying any provision before the payment of the first premium, separation of funding intermediaries (to start up) and payment of provisions.	1	2	3	4	5	6	?

What other measures or procedures can you mention concerning intermediary fraud risk?

1.

2.

3.

Please also mark the importance (1 to 6 or “?”)

Experience in practice

12. Are your replies with respect to fraud risk indicators and anti-fraud measures based on a theoretical knowledge, general perception or practical experience (for example fraud in your company)? Please specify in the next box.

Problems in the battle against fraud

13. What are in your opinion the biggest problems in the fight against fraud?

1.

2.

3.

Please send this questionnaire by email to Peter van den Broeke, chairman of the Insurance Fraud Subcommittee of the IAIS:

- p.vandenbroeke@dnb.nl.

If you prefer to send the document by mail, please use the following address:

The Dutch Central Bank

Véronique Hiji

Tb AOI, S6.28

Postbus 98

1000 AB Amsterdam

The Netherlands

We would appreciate very much receiving your replies no later than June 9th 2006

Thank you very much for your cooperation!