GUIDELINES ON INSURANCE FRAUD RISK MANAGEMENT IN INSURANCE AND TAKAFUL
GUIDELINES NO. TIU/G-4/2018/9

Amendment No. 1

1. INTRODUCTION

1.1. These Guidelines are issued pursuant to section 88 of the Insurance Order, 2006 ("IO") and section 90 of the Takaful Order, 2008 ("TO").

[Amendment No.1 dated 14 July 2022]

1.2. The Guidelines are issued to provide guidance on sound risk management practices to identify and mitigate insurers' exposure to the risk of insurance fraud. It articulates broad principles that should be embedded in a risk management framework covering strategy, organisational structure, policies and procedures for managing insurance fraud risk. These Guidelines should be read as Guidance to the Notice on Reporting of Insurance and Takaful Fraud [Notice No. TIU/N-3/2022/20], in particular in relation to paragraph 3 (Insurance Fraud Risk Management Practices) of the aforementioned Notice.

1.3. These Guidelines should also be read in conjunction with the following:

1.3.1. Notice on Corporate Governance for Insurance Companies and Takaful Operators [Notice No. TIU/N-3/2017/7];

1.3.2. Guidelines on Risk Management and Internal Controls for Insurance Companies and Takaful Operators [Guidelines No. TIU/G-3/2018/8];

1.3.3. {Deleted}

[Amendment No.1 dated 14 July 2022]

1.3.4. Guidelines on Outsourcing Arrangement for Insurance Companies and Takaful Operators [Guidelines No. TIU/G-1/2019/10]; and

[Amendment No.1 dated 14 July 2022]

1.3.5. Guidelines on Fit and Proper Criteria for key responsible persons and key persons in control functions in Insurance and Takaful [Guideline No: TIU/G-1/2017/6].

[Amendment No.1 dated 14 July 2022]

1.4. The Guidelines take effect on 1st January 2020.

2. DEFINITIONS

2.1. For the purposes of these Guidelines, unless the context otherwise requires:

2.1.1. "Authority" means Brunei Darussalam Central Bank as defined by the Brunei Darussalam Central Bank Order, 2010 ("BDCB Order");

[Amendment No.1 dated 14 July 2022]

2.1.2. "board" means the Board of Directors of the insurer;

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2.1.3. "insurance" includes takaful;

2.1.4. "insurer" means a registered insurance company under the IO and a registered takaful operator under the TO, unless it is otherwise specified; and

[Amendment No.1 dated 14 July 2022]

2.1.5. "senior management" shall have the same meaning as senior management defined in Notice on Corporate Governance for Insurance Companies and Takaful Operators [Notice No. N-3/2017/7].

[Amendment No.1 dated 14 July 2022]

3. FRAUD RISK IN INSURANCE

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

3.2. Fraud poses a serious risk to all insurers and policyholders. Fraudulent activities committed within or against the insurer can adversely affect an insurer's financial soundness and reputation. There may also be an indirect impact on the policyholders through premium increases arising from higher claims costs experienced by the insurer. The Authority takes seriously any suspected and actual fraudulent activities and expects all insurers to undertake sound practices in order to effectively deter, prevent and detect insurance fraud. Insurance fraud comes in all shapes and sizes and can be perpetrated by any party involved in insurance, including insurers, insurers' managers and staff, intermediaries, accountants, auditors, consultants, claims adjusters, third party claimants and policyholders.

3.3. Insurers should assess their own vulnerability and implement effective policies, procedures and controls to manage the risk of fraud, more specifically outlined in Paragraph 4.

3.4. The broad categories of insurance fraud include, but are not limited to, the following:

3.4.1. **Internal fraud** – Fraud against the insurer by a board member, senior manager, or other member of staff on his/her own or in collusion with others who are either internal or external to the insurer;

3.4.2. **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; and

3.4.3. **Intermediary fraud** – Fraud by intermediaries against the insurer, policyholders, customers or beneficiaries.

4. FRAUD RISK MANAGEMENT FRAMEWORK

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

4.1.1. Include a clear mission statement to indicate the insurer's level of tolerance to fraud;

4.1.2. Facilitate the development of quantitative risk tolerance limits on fraud;

4.1.3. Provide direction to the overall fraud management plan; and

4.1.4. Be reflected in the relevant operational procedures and controls for:

(a) Developing products;

(b) Accepting claims;

(c) Hiring and firing management and staff;

(d) Outsourcing;

(e) Handling claims; and

(f) Dealing with intermediaries.

4.2. A sound and prudent fraud management strategy should be compatible with the risk profile of the insurer. Relevant factors when formulating the risk profile of the insurer in relation to its fraud management strategy include:

4.2.1. Size, composition and volatility of its business;

4.2.2. Its organisational structure;

4.2.3. Complexity of its operations;

4.2.4. Products and services offered;

4.2.5. Remuneration and promotion policies;

4.2.6. Distribution modes; and

4.2.7. Market conditions.

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4.3. To ensure its relevance and adequacy, the fraud management strategy should be reviewed regularly by the board and senior management of the insurer to ensure that it continues to be effective, especially when there are material changes to the insurer's risk profile. The strategy should also be properly documented and effectively communicated to all relevant staff. There should be a process

to approve proposed deviations from the approved strategy, and systems and controls to detect unauthorised deviations.

4.4. The board and senior management of the insurer are ultimately responsible for the sound and prudent management of fraud risk. As part of their corporate governance, the board should recognise and understand the risks of fraud to their organisation, including the potential types and impact of fraud.

4.5. The board should put in place the fraud management strategy and ensure that adequate resources, expertise and support are provided for the effective implementation of the insurer's fraud management strategy, policies and procedures. Any deviation from the approved strategy and policies should be subject to the board's review and approval. The approved strategy should also be communicated to all staff.

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4.6. The insurer should establish clear policies and procedures for the management of fraud risk. These policies and procedures should:

4.6.1. Be well-defined and consistent with the insurer's fraud management strategy, as well as its overall risk management framework;

4.6.2. Be adequate for the nature and complexity of its activities; and

4.6.3. Address,

(a) The roles and responsibilities of the risk management function or staff assigned to execute the insurer's fraud management strategy, policies and procedures;

(b) The roles of the senior management and the board (if any) as being ultimately responsible for the sound and prudent management of fraud risk;

(c) Measures to identify and mitigate the risk of fraud;

(d) Measures to monitor and detect instances or suspicion of fraud;

(e) Clearly defined process of reporting of suspected fraud cases to designated person(s) for review and investigation, including clear trigger points for when to report such cases;

(f) Escalation to senior management and the board of suspected fraud cases;

(g) Record keeping of suspected or investigated fraud cases; and

(h) Regular training on fraud matters for its directors, management and staff.

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

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

4.9. There should be clear guidelines on the type of information to be reported to the board on a regular basis as well as when certain information or development ought to be communicated immediately to the board.

4.10. {Deleted}

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4.11. The insurer should provide regular training on anti-fraud measures to its board, senior management and members of its staff as appropriate. The type of training should correspond with the business process in which the person is engaged. Key personnel whom the insurer should consider providing regular training to include persons in the claims, finance and agency management and distribution functions.

5. RISK IDENTIFICATION, CONTROL AND MONITORING

5.1 Risk Identification and Measurement

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

(a) Adequacy of measures to verify customer information before accepting a customer's proposal, taking into consideration the risk factors posed by different distribution channels; and

(b) Fit and proper standards for its intermediaries.

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

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

5.1.4. Common indicators that could be used in the identification of fraud risk include:

(a) <u>Internal Fraud</u>

i. Key managers or members of staff having too much control and/or authority without oversight or audit by another person, or who resists or objects to (independent) review of their performance;
ii. Customer complaints;
iii. Missing statements and unrecognised transactions;
iv. Customers' records are not in the insurer's customer database even though proposal documents or payment has been provided to the insurer some time ago; and

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v. Rising costs with no explanation.

(b) Policyholder and Claims Fraud

i. Policyholder has been declined coverage by other insurers due to reasons such as non-disclosure or false disclosure of material information;

ii. Claimant is willing to settle claims for an inexplicably low settlement amount in exchange for a quick resolution;

iii. Claimant provides inconsistent statements or information to relevant parties such as the insurer or police; and

iv. Claimant made several claims of similar nature within a relatively short period of time.

(c) Intermediary Fraud

i. Evidence of churning of policies either within the insurer or across several product providers;

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

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

iv. Customers' records are not in the insurer's customer database even though proposal documents or payment has been provided to the intermediary some time ago; and

v. Indications that suggest that the intermediary is in financial distress.

5.2 Risk Identification and Measurement

Internal Fraud

5.2.1 An insurer should identify both the processes of their organisation that are vulnerable to internal fraud and the consequent individual internal fraud risks.

5.2.2 The insurer should also raise awareness of the potential for internal fraud within their organisation. For example, the board, senior management and other staff should be provided with guidance on potential internal fraud indicators and training on deterring, preventing, detecting, reporting and remedying internal fraud.

5.2.3 Members of the board and senior managers should meet the fit and proper criteria that are appropriate to their position and responsibilities as stipulated under the *"Guidelines on Fit and Proper Criteria for key responsible persons and key persons in control functions in Insurance and Takaful"* [Guideline No: TIU/G-1/2017/6] (hereinafter referred to as Guideline No: TIU/G-1/2017/6).

5.2.4 Insurers should observe the risk management practices as stipulated under *"Guidelines on Outsourcing Arrangement for Insurance Companies and Takaful Operators" [Guidelines No. TIU/G-1/2019/10].* (hereinafter referred to as Guideline No: TIU/G-1/2019/10) for third parties hired by insurers to perform activities in high risk areas.

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Policyholder and Claims Fraud

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

(a) Customer due diligence measures to be taken before business relationship is established for various product types; and

(b) Measures to be taken for unusual product-client combinations including the request for additional supporting documents. For instance, the insurer may request for additional information to verify whether the policyholder has other

sources of wealth such as inheritance, when the latter's normal earnings are not commensurate with the product purchased.

5.2.6 The measures referred to in paragraph 5.2.5(b) should be designed in order to detect incorrect or incomplete information provided by policyholders in their application for insurance cover, as well as incompatibility of the policyholder characteristics with the insured event, and should give due consideration to policyholder fraud indicators.

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

(a) Checks against indicators for claims fraud;

(b) Checks against internal database, industry members or other sources for confirmed or potential fraudsters; and

(c) Interviewing claimants and conducting special investigations for suspicious cases.

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

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

Intermediary Fraud

5.2.10 An insurer should adopt adequate measures to ensure that the intermediaries it deals with meet fit and proper standards. It should establish an internal assessment framework for the appointment of its intermediaries, taking into account the principles set out in the Guideline No: TIU/G-1/2017/6.

5.2.11 In assessing the fit and proper standards of its agents, the insurer should conduct adequate background checks including a search for any adverse records in reliable databases, if any. In addition, the insurer should conduct industry reference checks with the agents' previous employers using the standard reference check letter. The insurer should also develop a code of conduct for its agents, with appropriate penalties for non-adherence to the code or other misconduct by the agents.

5.2.12 The insurer which accepts business from financial advisers and insurance brokers should also ensure that the appointed firms' performances are reviewed periodically to ensure compliance with the insurer's fraud management controls.

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

(a) Ensure that policyholders' information such as mailing addresses are not altered without proper authorisation from or verification with the policyholders;

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

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

(d) Strongly encourage policyholders to make all cheques payable to the insurer only and take additional precautionary measures such as indicating the policy

number (for renewal policies) or the proposed policyholder's name and I.C. number (for new policies) on the back of the cheques;

(e) Enhance the monitoring of an intermediary's own insurance policies and those of his immediate family members when there are grounds for suspicion;

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

(g) Enhance monitoring of cheques received, through an intermediary, that are issued by third parties who are unrelated to the intermediary, to pay for policies owned by the intermediary or his immediate family members, when there are grounds for suspicion of fraud.

5.3 Risk Monitoring and Review

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

5.3.2 Insurers are also encouraged to establish an industry-wide database to facilitate the sharing of fraud-related information among industry players, so as to enhance insurers' ability to identify potential fraudsters and fraudulent transactions at an early stage.

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

5.3.4 The insurer should carry out periodic fraud-sensitive independent or internal audits to ensure compliance with its policies and procedures regarding insurance fraud risk. For example, the audit checks should include verification that whenever fraud risk indicators are triggered, they are properly and consistently dealt with and adequately documented.

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