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**MEDIA RELEASE: LIFE INDUSTRY FOILS FRAUDULENT AND DISHONEST CLAIMS WORTH MILLIONS**

For the information of members we circulate a media release issued today.

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## MEDIA RELEASE

### ASSOCIATION FOR SAVINGS AND INVESTMENT SOUTH AFRICA (ASISA)

1 JULY 2009

#### LIFE INDUSTRY FOILS FRAUDULENT AND DISHONEST CLAIMS WORTH MILLIONS

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The life insurance industry foiled fraudulent and dishonest claims worth R375.9-million last year, the highest ever since the industry started collecting claims fraud and non-disclosure statistics in 2003.

Peter Dempsey, deputy CEO of the Association for Savings and Investment South Africa (ASISA), points out that at the same time, however, the number of fraudulent and dishonest claims detected by the life insurance industry had declined to 1 382, the lowest number recorded since 2003.

“Therefore, while the industry has been successful in clamping down on fraud, the value of attempted cases has increased,” says Dempsey.

He says while the increase in the value of fraudulent and dishonest claims is of concern, by far the majority of claims submitted are honest and legitimate and are therefore honoured by life companies.

The life industry paid beneficiaries, policyholders and pension fund members more than R180.6-billion in claims last year. The fraudulent and dishonest claims recorded last year therefore represent less than 1% of total claims paid in 2008.

Dempsey says if life companies did not try and prevent claims fraud, the claims experience of life companies would increase substantially and ultimately force companies to recover these losses from customers.

#### **Material non-disclosure and misrepresentation**

Material non-disclosure and misrepresentation do not involve the criminal intent that comes with fraud and are therefore classified as dishonest claims.

Life companies reported 884 cases of material non-disclosure to a total value of R244.6-million last year. In 2007 the life industry reported 833 cases to a value of R127-million.

Dempsey says while the number of cases has decreased substantially in 2007 and 2008, the value of claims almost doubled in 2008. He says several ASISA member offices reported cases of material non-disclosure last year where the sums assured were between R2-million and R16-million. This, he says, drastically pushed up the value of material non-disclosure claims reported.

Material non-disclosure refers to the failure of policyholders to disclose important information about a medical or lifestyle condition.

Policyholders are legally obliged to honestly disclose all information likely to influence the judgment of the insurer when determining appropriate policy terms and premiums. Information generally regarded as material by a life insurer includes medical history, state of health, family medical history, life style, and financial status.

Misrepresentation occurs when policyholders do not fully disclose the seriousness of a medical or lifestyle condition on application, because they know that if the underwriter was made aware of the full risk, they would in all likelihood be required to pay a higher premium.

Dempsey says this category showed significant decreases in both the number of cases reported and the total value of the policies. The number of cases decreased from the 208 cases recorded in 2007 to 89 in last year and the value decreased from R69-million to R49-million.

“It is encouraging to see that policyholders are increasingly realizing that it is in their interest to be completely honest with their life company. It is much better to be completely honest about a medical condition and pay the appropriate premium than to run the risk of having a claim declined when you die or become disabled.”

### **Fraudulent documentation**

Forensic departments intercepted 311 claims based on fraudulent documentation last year. Had these claims not been stopped, the industry would have lost R60.1-million to fraud. In 2007 the number of cases involving fraudulent documents amounted to 385 cases worth R74.8-million.

One of the cases uncovered by forensic investigators involved a policyholder who submitted a number of fraudulent claims for a monthly disability benefit following neck surgery.

According to Dempsey the policyholder claimed that she had not recovered within the expected time and requested an extension to the benefit several times, supported by medical certificates. Later she claimed that her sick leave was exhausted and that she was not receiving any income other than the disability benefit. She substantiated a further claim with a letter from her manager and a letter from the payroll department as well as a medical report.

“During a routine enquiry to her employer, however, it was discovered that the employer had not submitted any documentation regarding the employee. On investigation it was found that all the documentation submitted was fraudulent and that she had returned to work after the initial claim period. The case has been reported to the police.”

### **Beneficiary and syndicate fraud**

The life industry reported 64 cases involving beneficiary and syndicate fraud to a value of just over R12-million in 2008.

Dempsey notes that there has been a R10-million increase over 2007 in the value of fraudulent claims involving beneficiaries and syndicates. In 2007 only 48 claims were uncovered to a value of just over R2-million.

Dempsey says while syndicate involvement contributes greatly towards claims fraud in the life industry, individual policyholders often appear on the radar screens of forensic departments as well.

He says one life insurer reported a case where the family of a policyholder submitted a death claim only four months after the life policy was issued.

“The policy had been issued to a healthy, yet overweight, 47 year old. According to the post-mortem report, however, the deceased individual was a chronically ill elderly woman who was suffering from a long-standing severe lung condition. This led to further investigation and it was found that the fingerprints were not those of the insured person. The claim was declined as the deceased was not the life assured.”

### Intermediary involvement

There was a slight decrease in fraud cases involving intermediaries, but the total value of these cases increased from R6.1-million in 2007 to R10.2-million last year.

Fraud involving intermediaries peaked at 809 cases in 2004 and dropped to 38 cases in 2007. Last year only 34 cases were reported.

Dempsey ascribes this decrease to tougher legislation that regulates intermediaries and their advice, as well as to increased consumer vigilance and early detection methods applied by the industry.

### Geographic spread

The highest number of fraudulent cases in 2008 were submitted in Kwa-Zulu Natal (42%), followed by Gauteng (23%) and then the Eastern Cape (12%). This pattern is consistent with cases recorded in 2007. Kwa-Zulu Natal and Gauteng have had the most cases of claims fraud and non-disclosure since 2003.

### Five year overview of fraudulent and dishonest claims statistics

Fraud Category	2004	2005	2006	2007	2008
Fraudulent documents	1 120 claims worth R33-million	3 615 claims worth R31.9-million	459 claims worth R21.1-million	385 claims worth R74.8-million	311 claims worth R60.1-million
Beneficiary and syndicate fraud	66 claims worth R6.6-million	57 claims worth R17.2-million	65 claims worth R4.2-million	48 claims worth R2-million	64 claims worth R12-million
Material non-disclosure	1353 claims worth R127.2-million	1919 claims worth R157.4-million	1369 claims worth R143.5-million	833 claims worth R127-million	884 claims worth R244.6-million
Misrepresentation	391 claims worth R32-million	2748 claims worth R138.5-million	805 claims worth R69.3-million	208 claims worth R69-million	89 claims worth R49-million
Intermediary involvement	809 claims worth R15.6-million	321 claims worth R2.1-million	146 claims worth R4.2-million	38 claims worth R6.1-million	34 claims worth R10.2-million

TOTAL	3739 claims worth R214 million	8660 claims worth R347.1- million	2844 claims worth R242.3- million	1512 claims worth R278.9- million	1382 claims worth R375.9- million
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ASISA represents the majority of South Africa's asset managers, collective investment scheme management companies, linked investment service providers, multi-managers, and life insurance companies. ASISA was formed in 2008 by members of the Association of Collective Investments (ACI), the Investment Management Association of South Africa (IMASA), the Linked Investment Service Providers Association (LISPA) and the Life Offices' Association (LOA).