Fraud Prevention Policy

March 2019
# Table of Contents

1. **Introduction** ................................................................................................................. 3  
   1.1 **Background** ............................................................................................................. 3  
   1.2 **Objective** ................................................................................................................... 3  
   1.3 **Applicability** ............................................................................................................. 4  
   1.4 **Review and approval of the policy** ............................................................................. 4  

2. **Policy Requirements** .................................................................................................. 4  
   2.1 **Procedures for Fraud Monitoring** ............................................................................. 4  
   2.2 **Identification and reporting of frauds and Potential Fraud** ........................................ 5  
   2.3 **Investigation Responsibilities** .................................................................................... 5  
   2.4 **Coordination with Law Enforcement Agencies** .......................................................... 5  
   2.5 **Framework for Exchange of Information** ................................................................. 5  
   2.6 **Due Diligence** ............................................................................................................ 5  
   2.7 **Regular Communication Channels** .......................................................................... 5  
   2.8 **Preventive mechanism** .............................................................................................. 6  
   2.9 **Disciplinary Measures** .............................................................................................. 6  
   2.10 **Responsibilities** ....................................................................................................... 6  

3. **Record keeping** ............................................................................................................ 6  

4. **Appendices** .................................................................................................................. 6  
   4.1 **Definition** .................................................................................................................... 6
1. Introduction

1.1 Background

In accordance with Insurance Fraud Monitoring Framework, dated January 21, 2013 (hereinafter referred to as “the Framework”), SBI Life Insurance (hereinafter referred to as “the Company”) is required to have in place an Anti-Fraud Policy (hereinafter referred to as “the Policy”), duly approved by the Board of Directors.

Further, as laid down in the “Guidelines on Insurance e-commerce” dated March 9, 2017, an Insurer is required to have a pro-active fraud detection policy for insurance ecommerce activities, which is to be approved by the Board of Directors.

Also, Corporate Governance Guidelines for Insurance Companies dated May 18, 2016 issued by IRDAI, requires insurance companies for formulation of a Fraud monitoring policy and framework for effective deterrence, prevention, detection and mitigation of frauds. The Corporate Governance guidelines mandate insurance companies to set up a Risk Management Committee (RMC). The RMC is required to lay down the Company-wide Risk Management Strategy.

As part of the Responsibility Statement which forms part of the Management Report filed with the Authority under the IRDAI (Preparation of Financial Statements and Auditors Report of Insurance Companies) Regulations, 2002, the management of an insurance Company is required to disclose the adequacy of systems in place to safeguard the assets for preventing and detecting fraud and other irregularities, on an annual basis.

Accordingly, the Policy has been formulated considering the various types of frauds including e-commerce frauds that the Company can be exposed to. This Policy has been further devised to ensure that the fraud detection framework is in line with the requirements as laid down under the Framework, as well as it recognizes the principle of proportionality and reflects the nature, scale and complexity of the business of the Company and risks to which it is exposed. The Policy shall also provide guidance with respect to prevention, detection, mitigation and investigation into fraudulent activities related to ecommerce.

1.2 Objective

The Policy is established to detect, monitor and mitigate occurrence of insurance fraud in the Company. It would facilitate development of processes to prevent, detect and manage frauds. Further it will also ensure development of control measures at an organizational level and conducting investigations. The Company is committed to conducting business in an environment of fairness and integrity, and will strive to eliminate fraud from all operations.

The Company adopts a “Zero-Tolerance” approach to fraud and will not accept any dishonest or fraudulent act committed by internal and external stakeholders.
1.3 Applicability

This Policy applies to any fraud or suspected fraud involving employees as well as shareholders, consultants, vendors, contractors, outside agencies doing business with the Company and/or any other parties having a business relationship with the Company including insurance advisors/ brokers/ corporate agents of the Company. Any investigation activity required will be conducted irrespective of the suspected wrongdoer’s length of service, position/title, or relationship to the Company.

1.4 Review and approval of the policy

This policy is owned by Risk Management and Fraud Monitoring Department.

Adherence to this policy and all resulting procedures and guidelines is the responsibility of all employees.

2. Policy Requirements

2.1 Procedures for Fraud Monitoring

The Company will have well defined procedures to identify, detect, investigate and report insurance frauds. The company will have team for Developing/Managing systems and analytical tool methodologies to identify potential fraud areas at the first stage and a second level identification through sampling methodology to identify patterns to review processes based on above, and put in place corrective and preventive measures and report to the RMC which oversee the Fraud Monitoring functions. It also spreads awareness regarding fraud prevention across the Organization to develop a culture of zero tolerance to fraud.

a) The company will have team for centralized investigation. All incidents and complaints with suspected fraudulent activity are investigated, analysed, queries generated to initiate the mode of investigation and post investigation conclusions after due validation of evidences to be put up to the Disciplinary Authority for taking appropriate punitive action.

b) All Functional Heads are primarily responsible for day to day management of activities and in charge of maintaining, implementing and improving their Systems & Controls so that they minimize the possibility of frauds.

c) The Heads of various departments at Corporate Office, Central Processing Centre and Regional Directors will submit a quarterly report regarding identification and reporting of fraud, if any, in their functional/ geographical area.
2.2 Identification and reporting of frauds and Potential Fraud

All the frauds detected by any departments and/or detected by any person with knowledge of confirmed, attempted or suspected fraud or any person who is personally being placed in a position by another person to participate in a fraudulent activity shall be reported to and by the Functional Heads within 48 hours from the detection of any confirmed, attempted or suspected fraud via the online incident reporting system i.e. ORMS (Operational Risk Management System).

Any known fraud to one or more SBI Life employees being not reported will be considered very seriously and disciplinary actions will be initiated against the person withholding the information as laid down in the penalty matrix.

2.3 Investigation Responsibilities

The centralised Investigation Dept. is entrusted with the full authority for the investigation of all suspected/actual fraudulent acts as defined in this policy. It will take the necessary support from all concerned departments, External outsourced investigation agencies, and forensic experts for investigation if required. Moreover, Members of the Investigation Team will be given all rights, authority to investigate any Company’ records, books, desks, cabinets, storages, emails, files and/or access to any premises etc. whatsoever to investigate the case. The department will work as per the roles and responsibilities laid down in internal guidelines.

2.4 Coordination with Law Enforcement Agencies

The Company will laid down procedures to coordinate with various law enforcement agencies for fraud reporting on timely and expeditious basis and follow-up processes thereon. Reporting to CBI/ Police and other law enforcement agency not specifically mentioned will be done on case to case basis.

2.5 Framework for Exchange of Information

The Company will also lay down procedures for exchange of necessary information on frauds amongst all insurance players through Life Council as and when required. The Company to aid in setting up coordination platforms through Life Council or any other Forum to establish information sharing mechanism.

2.6 Due Diligence

The Company shall ensure that there are adequate procedures in place at various departments for carrying out due diligence on the various entities/ people with whom the Company carries out its business before entering into agreement/ or their appointment, for e.g. Personnel, insurance agent, corporate agent, intermediary, TPA etc.

2.7 Regular Communication Channels

The Company will have to generate fraud mitigation communication within the organization at periodic intervals on an adhoc basis, as may be required. It has to also ensure information flow amongst the various operating departments as regards frauds.
2.8 Preventive mechanism

The Company will inform stakeholder about its Fraud Prevention Policy. The Company will incorporate necessary caution in the insurance contracts/ relevant documents duly highlighting the consequences of submitting a false statement and/or incomplete statement, for the benefit of policyholders, claimants and beneficiaries.

2.9 Disciplinary Measures

Based on the investigation report, staff accountability and complicity will be decided. Measures will be built in place to recover the amount fully. Based on the nature of the fraud, an internal disciplinary committee may decide on suitable penal action, or the matter may have pursued with other law enforcement agencies for appropriate action against the concerned staff.

2.10 Responsibilities

2.10.1 Other departments

Implementation of management decisions arising out of investigation carried out will be the responsibility of respective departments.

3. Record keeping

All documents shall be preserved for a period as specified in the applicable regulations.

4. Appendices

4.1 Definition

4.1.1 “Broad Categories of Fraud”

- **Policyholder fraud and/or claims fraud** – Fraud against the insurer in the purchase and/or execution of an insurance product, including fraud at the time of making a claim
- **Intermediary fraud** – Fraud perpetuated by an insurance agent/ Corporate Agent/ intermediary/ Third Party Administrators (TPAs) against the insurer and/or policyholders.
- **Internal fraud** – Fraud/ misappropriation against the insurer by its Director, Manager and/or any other office or staff member (by whatever name called)

4.1.2 “Fraud” means in insurance is an act or omission intended to gain dishonest or unlawful advantage for a party committing the fraud or for other related 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 the financial decision, transaction or perception of insurer’s status;
- Abusing responsibility, a position of trust or a fiduciary relationship.