SBI LIFE INSURANCE COMPANY LIMITED

POLICY TITLE	Fraud Prevention Policy

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1.0 BACKGROUND & PURPOSE

1.1 Background

IRDAI vide its circular no. IRDA/SDD/MISC/CIR/009/01/2013 dated 21st January 2013, has issued guidelines to all insurance companies on Fraud Monitoring Framework.

SBI Life Insurance Company Ltd. ("the Company") already has a Fraud Prevention Policy in place.

The Policy recognizes the principle of proportionality and reflects the nature, scale and complexity of the business of specific insurers and risks to which they are exposed. The policy gives due consideration to all relevant factors including but not limited to the organisational structure, insurance products offered, technology used, market conditions, etc. As fraud can be perpetrated through collusion involving more than one party a holistic approach to adequately identify, measure, control and monitor fraud risk is implemented and lays down appropriate risk management policies and procedures across the organization.

1.2 Purpose

This corporate Fraud Prevention Policy is established to detect, monitor and mitigate occurrence of insurance fraud in the Company. It would facilitate the development of controls which will aid in the detection, prevention and management of fraud against the Company. It is the intent of the Company to promote consistent organizational behaviour by following guidelines and assigning responsibility for the development of controls and conduct of investigations.

The Policy seeks to lay stress on prevention and detection of frauds through early warning symptoms and prompt initiation of appropriate corrective measures to pre-empt attempts to breach the system.

2.0 SCOPE

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 without regard to the suspected wrongdoer's length of service, position/title, or relationship to the Company.

3.0 DEFINITIONS

1. **Fraud** – Fraud 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.

2. **Broad Categories of Fraud:**

a. **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

b. **Intermediary fraud** – Fraud perpetuated by an insurance agent/ Corporate Agent/ intermediary/ Third Party Administrators (TPAs) against the insurer and/or policyholders.

c. **Internal fraud** – Fraud/ misappropriation against the insurer by its Director, Manager and/ or any other office or staff member (by whatever name called)

Illustrative list of Insurance Frauds is given in Annexure

4.0 POLICY STATEMENT

In order to adequately protect itself from the financial and reputational risks posed by insurance frauds, the Company will have in place appropriate framework to detect, monitor and mitigate occurrence of insurance frauds within the Company.

4.1 Procedures for Fraud Monitoring

The Company will have well defined procedures to identify, detect, investigate and report insurance frauds. The Company will have a 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-E [Risk Management Committee-Executive 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) 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.

b) 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.

4.2 Identification and reporting of frauds and Potential Fraud

As the primary responsibility of fraud prevention set up lies with Functional Heads, they are responsible to ensure proper reporting within 48 hours from the detection of any confirmed, attempted or suspected fraud via the online incident reporting system ie ORMS (Operational Risk Management System). (). 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 will have to report the case according to the process defined by the Functional Head.

If during an investigation it appears that the case was known to one or more SBI Life employee(s) but not reported, the same will be considered very seriously and disciplinary actions will be initiated against the person withholding the information as laid down in the penalty matrix.

Any abuse of the fraud reporting (for example, any false or bogus allegations made by a person knowing them to be false or bogus or with a malafide intention) will warrant disciplinary action.

4.4 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.

4.5 Framework for Exchange of Information

The Company will 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.

4.6 Due Diligence

The Company will have 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.

4.7 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.

4.8 Reporting to the IRDAI

The Company will submit the report on various fraudulent cases which come to light and action taken thereon to be filed with the IRDA in forms FMR 1 and FMR 2 providing details of:

(i) Outstanding fraud cases and
(ii) Closed fraud cases

every year within 30 days of the close of financial year.

4.9 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.

4.10 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 pursued with other law enforcement agencies for appropriate action against the concerned staff.

Illustrative List of Insurance Frauds

Broadly, the potential areas of fraud include those committed by the officials of the insurance company, insurance agent/corporate agent/intermediary of TPAs and the policyholders/ their nominees. Some of the examples of fraudulent acts/omissions include, but are not limited to the following:

1. Internal Fraud:

a) Misappropriating funds
b) Fraudulent financial reporting
c) Stealing cheques
d) Overriding decline decisions so as to open accounts for family and friends
e) Inflating expenses claims/over billing
f) Paying false (or inflated) invoices, either self-prepared or obtained through collusion with suppliers
g) Permitting special prices or privileges to customers, or granting business to favoured suppliers, for kickbacks/favours
h) Forging signatures
i) Removing money from customer accounts
j) Falsifying documents
k) Selling insurer's assets at below their true value in return for payment.

2. Policyholder Fraud and Claims Fraud:

a) Exaggerating damages/loss
b) Staging the occurrence of incidents
c) Reporting and claiming of fictitious damage/loss d) Medical claims fraud
e) Fraudulent Death Claims

3. Intermediary fraud:

a) Premium diversion-intermediary takes the premium from the purchaser and does not pass it to the insurer / misuses for other Policies
b) Sourcing business without meeting the proposer of insurance.
c) Inflates the premium, passing on the correct amount to the insurer and keeping the difference
d) Non-disclosure or misrepresentation of the risk to reduce premiums
e) Commission fraud - insuring non-existent policyholders while paying a first premium to the insurer, collecting commission and annulling the insurance by ceasing further premium payments.
f) Misuse of Renewal Premium for issuance of New Business.
g) Adverse selection of clients for insurance cover.