# Anti-Fraud Policy

# For

# Max Life Insurance Company Limited

| | |
|---|---|
| **Version** | **2.1** |
| **Effective from** | **1st April 2013** |
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## 1. Introduction

Max Life is committed to transparency, integrity and accountability in all its affairs. It is determined to maintain a culture of honesty and strong opposition to fraud and corruption.

Like any other organization of significant size and complexity, Max Life is vulnerable to risks of fraud and corruption and as such, in accordance with the principle of proportionality, has dedicated adequate resources and priority to combat the same.

The above objective is reinforced through Max Life's **Anti-Fraud Policy** ("Policy") which outlines the procedures in relation to its five key fraud pillars, namely

- Prevention;
- Identification and detection;
- Investigation
- Correction; and
- Monitoring and reporting of frauds.

Max Life's Anti-Fraud Policy is administered through a dedicated Fraud Prevention & Control Unit which is part of the Internal Assurance Function.

This Policy shall be read in conjunction with the following:

- IRDAI Circular on Fraud Monitoring Framework, dated 21 Jan 2013 (Circular No. IRDAI/ SDD/ MISC/ CIR/ 009/ 01/ 2013) and "Guidelines on Insurance e-commerce" dated March 9, 2017 along with any modifications

- Max Life HR and Compliance policies, including
    - Business Code of Conduct;
    - Conflict of Interest Policy
    - Employee Background Verification Policy;
    - Whistleblower Policy;
    - Anti- Bribery & Anti Corruption Policy; and
    - Information Security Policy.

All the business functions are required to have in place procedures and controls that are in compliance with the Max Life Anti-Fraud Policy and the line managers are entrusted with the primary responsibility to enforce its adherence in the normal course of business.

## 2. Purpose & Intent

The Policy has been formulated to:

- Develop amongst the employees and other stakeholders, the understanding of Fraud and its implications and effects on the Company.
- Create awareness with respect to Fraud and spread a culture in the Company to prevent the occurrence of Fraud.
- Send across a message within the Company and to the public at large that Fraud is not acceptable and shall not be tolerated.
- Ensure that the employees including senior management of the Company is aware of its roles and responsibilities for the detection and prevention of fraud and for implementing procedures to prevent and/or detect fraud;
- Provide a mechanism to report any actual/ suspected incident of fraud.

- Define the action to be taken by the Company when any actual or suspected fraudulent activity occurs
- Adequately protect the organization from the financial and reputational risks posed by Insurance and other frauds.
- Put in place the framework to identify, assess & minimize the risk of fraud thereby protecting and further strengthening of customers as well as shareholder's confidence.

## 3. Definition and Scope

As per section 447 of Companies Act 2013, explanation of "fraud" is as below:

(i) "fraud" in relation to affairs of a company or anybody corporate, includes any act, omission, concealment of any fact or abuse of position committed by any person or any other person with the connivance in any manner, with intent to deceive, to gain undue advantage from, or to injure the interests of, the company or its shareholders or its creditors or any other person, whether or not there is any wrongful gain or wrongful loss;
(ii) "Wrongful gain" means the gain by unlawful means of property to which the person gaining is not legally entitled;
(iii) "Wrongful loss" means the loss by unlawful means of property to which the person losing is legally entitled.

As per IRDAI Circular on Fraud Monitoring Framework dated 21 Jan 2013, 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 financial decision, transaction or perception of Max Life's status; and
- Abusing relationship, a position of trust or a fiduciary relationship.
- E-commerce fraud such as Identity fraud, Phishing, Sniffer attack, Card testing fraud, Data modification and Identity Spoofing (IP address Spoofing)

Max Life's Anti-Fraud Policy applies to actual or suspected frauds involving employees or person associated with Max Life, including but not limited to its agents, vendors, brokers or other business parties with which Max Life has a business relationship.

Legal recourse with respect to the money defrauded and those criminally involved would be as per the Law of the Land. The following are the broad categories of fraud as per the IRDAI circular on Fraud Monitoring Framework:

- **Policyholder Fraud and/or Claims Fraud**: Frauds by policyholders / third parties against Max Life 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 Agent Advisor/ Corporate Agent/ Intermediary/ Third Party Administrator (TPAs) against Max Life and/ or Policyholders.
- **Internal Fraud**: Fraud / misappropriation against Max Life by its Directors, Managers and/ or any other officers or staff members or employees or ex-employees and vendor associates of the Company by whatever name called.
- **Third party fraud**: Any fraud done by an external party (including parties who have no business relationship with Max Life) against the Company and the general public which may include activities such as issue of fake policies in the name of Max Life.

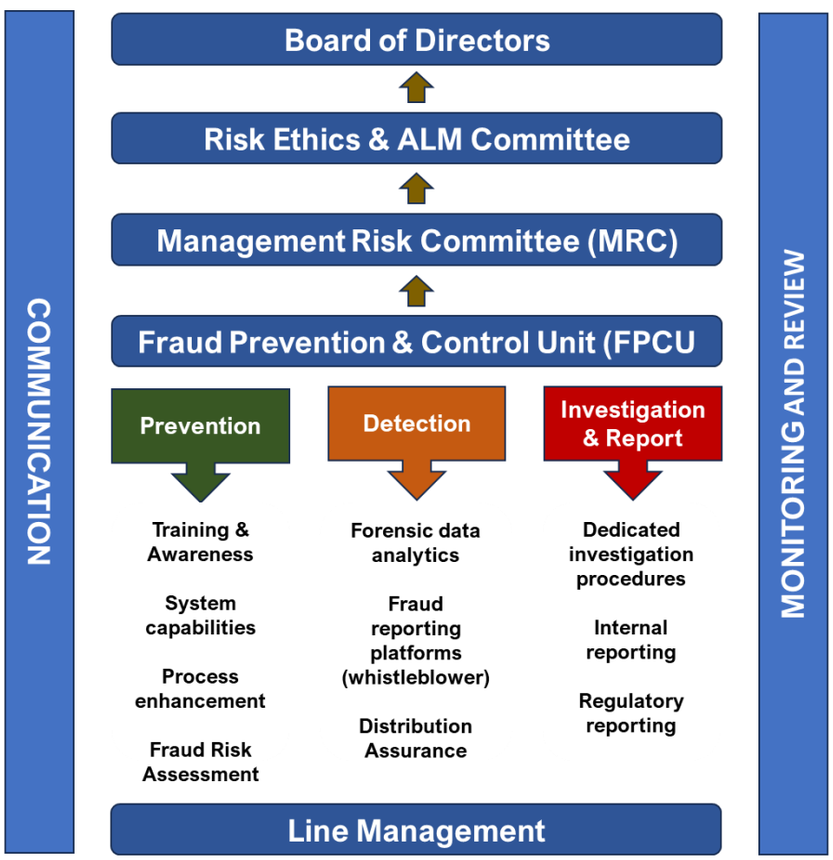
An illustrative list of frauds is given in Appendix 1 of this note.

## 4. Fraud Monitoring Framework

In response to the growing threat of fraud and vulnerability due to significant size of its operations and the nature of business, Max Life has put in place a comprehensive Fraud Monitoring Framework. This framework recognizes fraud risk as part of the key risks and provides for its periodic review by the management and also by the various review committees such as Management Risk Committee, Risk Committee and the Board etc. However, the Line Management holds primary responsibility including its applicability, monitoring, reporting and implementing corrective measures.

The framework further provides for dedicated processes and teams of specialists embedded within a dedicated Fraud Prevention & Control Unit **(FPCU) under Internal Assurance.**

The following diagram shows the Max Life **Fraud Monitoring Framework**:




The Fraud Prevention & Control Unit is responsible for effective implementation of the Anti-Fraud Policy of the Company and shall also be responsible for the following:

a) Laying down procedures for internal reporting from/and to various departments,

b) Creating awareness among employees/ Sellers /policyholders to counter insurance frauds,

c) Furnishing various reports on frauds to the authority as stipulated in this regard;

d) Carrying out investigations with respect to financial and non-financial frauds e.g. mis-selling, suspicious claims, mortality frauds, information security breaches, behavioral and misconduct related issues etc. and

Furnishing periodic reports to the board of Directors and various committees for their review.

In order to discharge its responsibilities of companywide monitoring and reporting of frauds, the Fraud Prevention & Control Unit works closely with:

- **Claims:** Claims team assesses the need for investigation basis the defined parameters and guidelines for reported claims. The suspected claims are assigned for investigation to Fraud Prevention & Control Unit and based on incriminating evidence so procured, fraudulent claims are recommended for repudiation to the Claims team.

- Information Security Unit: This team is responsible for driving implementation and reviewing Information Security processes within **ISO 27001** Framework. Incidents, involving information security breaches, are investigated by Information Security Unit. Repeated incidents and incidents of significant nature are assigned to Fraud Prevention & Control Unit.

- Underwriting Risk Management Unit (URMU): URMU forms part of the Underwriting Function and aims to mitigate the underwriting and operational fraud risk at the time of policy issuance. The unit identifies exceptional/ suspicious cases through back end analytics and for suspicious transactions performs further checks including field verifications.

- **Human Resources (HR):** HR team provides necessary inputs and support for investigation of any fraud or misconduct involving employees and also for finalizing the disciplinary action against the established cases of Fraud or Misconduct.

- Fraud instances at the entity level are collated and reported quarterly to Operational Risk Group and Management Risk Committee.

A brief snapshot on the key activities under the Fraud Monitoring Framework is provided below:

## 4.1 Prevention

Prevention of fraud involves identifying the cause of an integral fraud risk by means of risk assessment and implementing effective controls to stop fraud before it happens: The organization invests considerable efforts into prevention/ mitigation measures such as:

### 4.1.1 Training and Awareness

- Training and awareness on internal controls, fraud detection and prevention is conducted by Fraud Prevention & Control Unit at periodic intervals so as to cover all employees once a year. Advisories on emerging fraud risks are published by Fraud Prevention & Control Unit based on learning derived from emerging fraud issues on at least annual basis.

- Training on compliance and regulatory framework (including Anti Money Laundering) is done by Compliance function for employees and by the Training Team for agents to cover employees/agents once a year.

- Both potential and existing customers should be informed about the anti-fraud policy, necessary cautions are to be included in insurance contracts/ relevant documents, highlighting the consequences of submitting a false statement and/ or incomplete statement.

4.1.2 Due Diligence

Due Diligence is a process of verifying the background and credentials of the personnel (management and staff) / Insurance agent / Corporate Agent / Intermediary / Vendors. Max Life has laid down the broad procedures below for conducting due diligence:

- Employees (Management and Staff): Employee background verification is conducted by Human Resources by checking the background (professional and educational) of the new hires.
- Insurance Agents: Agent background verification is conducted through reference checks and Know Your Customer (KYC) checks by Distribution Service Delivery Operations (DSDO) before their appointment.
- Corporate Agents and Sellers: Due Diligence for Corporate Agents and Sellers is conducted by Legal and Compliance before entering into agreements with them.
- Vendors: Due Diligence for Vendors is conducted by Procurement as per the Procurement Policy before entering into agreements with them.

4.1.3 Fraud Risk Assessment (FRA) identifies and recognizes fraud risks in the organization, determines their likelihood and how to prevent and mitigate the fraud risks proactively.

## 4.2 Identification and detection

Fraud detection is the identification of actual or potential fraud. It relies upon the implementation of appropriate systems and processes to get early warning signs of fraud.

Fraud identification and detection includes a combination of the following techniques:

4.2.1 The primary responsibility for detection and fraud Prevention set up lies with the functional heads. Further Department wise anti-fraud procedures are embedded into processes such as:

- Segregation of duties;
- Inbuilt maker-checker controls.
- System access controls – access rights restricted as per job responsibilities;
- Quality checks;
- Scrutiny of application / proposal forms;
- Delegation of authority matrix;

4.2.2 Customer Complaint Management System – Centralized system for logging and tracking policyholder grievances (received through letters, online, on call or email) for monitoring market conduct issues etc.

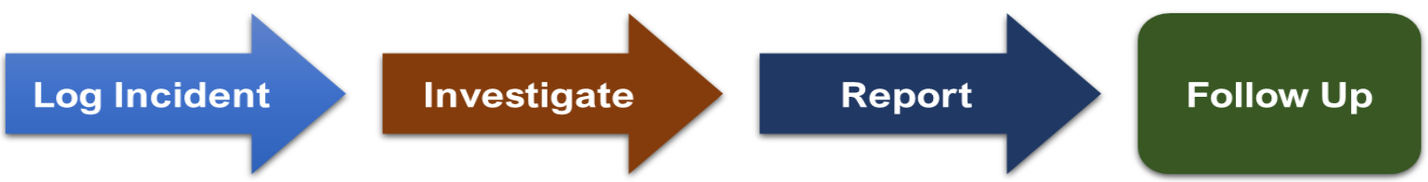
4.2.3 Whistleblower Policy: This policy aims to provide employees an avenue to anonymously raise concerns regarding any fraud or misconduct including violation of Business Code of Conduct, Conflict of Interest and instances of non-compliance to policies and procedures, laws and regulations.

Any employee who discovers or suspects fraudulent activity ("Concern") must raise it via modes and in the manner as described in Whistleblower Policy for appropriate action.

4.2.4 Offsite Monitoring /Surveillance: Under the Fraud Monitoring Framework, data-mining procedures using analytical techniques on an ad-hoc, repetitive or continuous basis are part of the surveillance conducted. It is particularly useful for analyzing operational and transactional information to highlight anomalies or identify fraud 'red-flags' such as unusual or suspicious gaps (examples – cheques being issued by agents, signature mismatch cases in multiple policies, impersonation by sellers to receive fraudulent customer payouts, etc.). Information derived from data mining is acted upon and reviewed by Fraud Prevention & Control Unit. Mystery shopping as a tool is proactively used to identify and detect frauds. The list above is illustrative only, not exhaustive.

### 4.3 Investigation

Investigations shall be undertaken independently, objectively, and professionally in a manner that preserves confidentiality and in accordance with laws and regulations. Investigation includes performing root cause analysis through identifying the point of control failure along with necessary corrective and preventive actions and follow-up for recovery of fraud losses wherever applicable. Brief process is as follows:




Detailed process is set out in the Appendix 2 of this note.

Investigation Unit of the Fraud Prevention & Control Unit is responsible to ensure;

- Utmost confidentiality is maintained of the person reporting the incident in good faith.
- Information relating to investigation is shared strictly on 'legitimate need to know' basis.
- Reported cases are investigated within least possible time and reports issued accordingly.
- To abstain from any conflict of interest in accordance with 'conflict of interest' policy of Max Life.

Members of the Investigating Unit are empowered to:

- Have free and unrestricted access to the Company's records and premises, whether owned or rented.
- Obtain full co-operation from any employee or associate of the organization.
- Obtain written and / or oral statements from people they may deem fit, provided such enquiries are under the scope of current investigation.
- Examine, copy, and / or seize/ obtain all or any portion of the contents of files, desks, cabinets, and other storage facilities including personal items linked to the fraud on the premises without prior knowledge or consent of any individual who may use or have custody of any such items or facilities when it is within the scope of their investigation.

All the relevant evidences obtained during the course of investigation must be preserved as the same may be required to support legal proceedings.

Where legally required by law enforcement and regulatory bodies or government agencies, Management is to ensure that all cases of fraud or malpractice are adequately reported.

4.3.1 Coordination with law enforcement Agencies

Coordination with law-enforcement agencies will be done as per the investigation procedure set out in Annexure 2, including the reporting of frauds on timely and expeditious basis and follow-up process thereon. Decisions, as to the timing of the involvement of the Police or Legal Advisors, will vary on a case by case basis.

The recovery of monies lost due to fraud should be actively pursued using available legal means where appropriate.

## 4.4 Reporting

As per IRDAI Circular on Fraud Monitoring Framework dated 21 Jan 2013, communication channels are to be established between all stakeholders to provide detailed information of incidents investigated as per format FMR1 and FMR2 (For format details refer Appendix 3 of this note). This information is to be collated and presented to management on a quarterly basis. The table below shows the frequency of reporting internally and externally.

| S.No. | Internal/ External | Frequency | Reporting Deliverables | Responsibility |
|---|---|---|---|---|
| **I** | **Internal** | Quarterly | Report to be published to 'Management Risk Committee' (MRC) and '(Risk Committee)' containing details of frauds reported | Fraud Prevention & Control Unit |
| **II** | | Annual | 'Annual Fraud Report' to be published to the 'Management Risk Committee' (MRC) and ' (Risk Committee)' to highlight the nature of key incidents investigated, emerging frauds experienced and the initiatives undertaken to combat the same. | Fraud Prevention & Control Unit |
| **III** | **External** | Annual | Submission of fraud monitoring report (FMR 1 & 2) to IRDAI as per the IRDAI circular (Refer Annexure 3) | Fraud Prevention & Control Unit |
| **IV** | **External** | Quarterly | Submit a quarterly report on individual frauds of serious nature with amount >INR 1 Crore to the 'Management Risk Committee' for the review and submit to the authority. Action taken report to be submitted within one month from the date of placing the report before the Management Risk Committee | Fraud Prevention & Control Unit |

4.4.1 Framework for exchange of information

As required under the circular on Fraud Monitoring Framework, Fraud Prevention & Control Unit will share any significant fraud with the other insurers through the Life Council. Max Life will share relevant data for industry fraud repository or other such industry initiatives through Life Council or other appointed bodies formed at industry level such as Indian Insurance Bureau (IIB)

## 5. Failure to comply with the Anti-Fraud Policy

The failure to comply with this Policy will result in appropriate disciplinary actions, up to and including termination, including further legal and regulatory actions against the individuals involved as may be required as per the Employee Disciplinary Action (E-DAP)/ Agent Disciplinary Action process (A-DAP) note and according to local laws and regulation. Further, for cases where fraud is established, criminal proceedings in consultation with the legal function will be initiated which may be punishable with fine, imprisonment, or both. Max Life employees/sellers would be responsible to make good the financial loss to Max Life caused by their fraudulent actions

## 6. Communication and Administration

The Anti-Fraud Policy will be communicated to all stakeholders, including employees, vendors, agents, Sellers and Customers. It is the responsibility of the process owners to inform their relevant staff, including vendors about the stipulations on fraud detection, classification, monitoring and reporting as per the Max Life Anti-Fraud Policy.

The Anti-Fraud Policy will be updated periodically, at least on annual basis to support current Max Life policies, emerging business risks, regulatory changes and other emerging requirements.

As per IRDAI Circular on Fraud Monitoring Framework dated 21 Jan 2013, the Anti-Fraud Policy is to be duly approved by the board. The Board shall review the Policy on at least an annual basis or at other such intervals as it may be considered necessary.

## Appendix 1 – Illustrative list of frauds

As per IRDAI Circular on Fraud Monitoring Framework dated 21 Jan 2013, broadly, the potential areas of fraud include those committed by the officials of the insurance company, insurance agent/corporate agent/intermediary/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 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:**

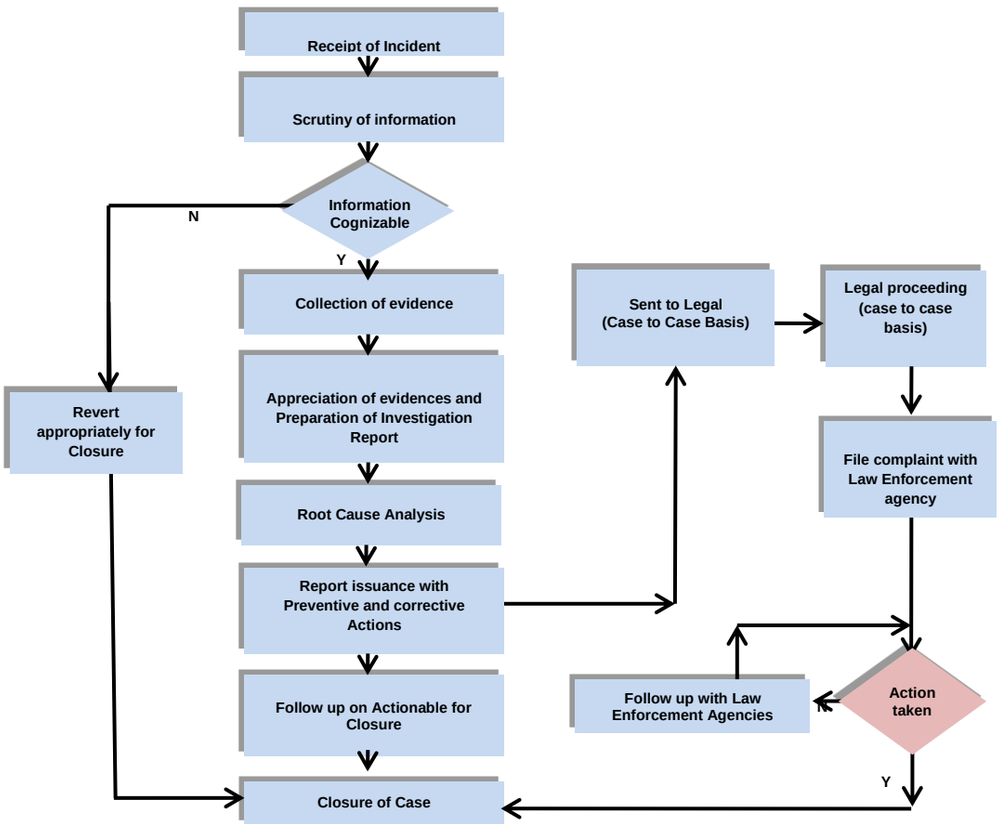
a) Premium diversion-intermediary takes the premium from the purchaser and does not pass it to the insurer

b) Inflates the premium, passing on the correct amount to the insurer and keeping the difference

c) Non-disclosure or misrepresentation of the risk to reduce premiums

d) 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.

## Appendix 2 – Investigation process (case to case basis)




## Appendix 3 – Format for reporting

**FMR – 1 - Fraud Monitoring Report**

| |
|---|
| Name of the Insurer:<br><br>Report for the year ending |

**Part I - Frauds Outstanding- Business segment wise *:**

| Sl. No. | Description of Fraud | Unresolved Cases at the beginning of the year | | New cases detected during the year | | Cases closed during the year | | Unresolved Cases at the end of the year | |
|---|---|---|---|---|---|---|---|---|---|
| | | No. | Amount involved (INR Lakhs) | No. | Amount involved (INR Lakhs) | No. | Amount involved | No. | Amount involved (INR Lakhs) |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | (INR Lakhs) | | |
| | | | | | | | | | |
| | **Total** | | | | | | | | |

**Part II - Statistical details: (unresolved cases as at end of the year) –Business segment wise***

| **Sl. No.** | **Description of Fraud** | **No. of Cases** | **Amount Involved (INR Lakhs)** |
|---|---|---|---|
| | | | |
| | | | |
| | **Total** | | |

**Part III - Preventive and Corrective steps taken during the year- Business segment wise***

| **Sl. No.** | **Description of the fraud** | **Preventive/Corrective action taken** |
|---|---|---|
| | | |
| | | |

**Part IV**

**Cases Reported to Law Enforcement Agencies**

| Sl. No. | Description | Unresolved Cases at the beginning of the year | | New cases reported during the year | | Cases closed during the year | | Unresolved cases at the end of the year | |
|---|---|---|---|---|---|---|---|---|---|
| | | No. | (INR Lakhs) | No. | (INR Lakhs) | No. | (INR Lakhs) | No. | (INR Lakhs) |
| | Cases reported to Police | | | | | | | | |
| | Cases reported to CBI | | | | | | | | |
| | Cases reported to Other agencies (specify) | | | | | | | | |
| | **Total** | | | | | | | | |

* Business segments shall be as indicated under IRDAI (Preparation of Financial Statements and Auditor's Report of Insurance Companies) Regulations, 2002

CERTIFICATION

Certified that the details given above are correct and complete to the best of my knowledge and belief and nothing has been concealed or suppressed.

Date: Signed/-
Place: Name of the Chief Executive Officer of the Insurer

**FMR – 2 - Fraud Cases closed during the year**

| |
|---|
| Name of the Insurer:<br><br>Report for the year ending |

| Sl. No. | Basis of closing a case | Number of cases closed |
|---|---|---|
| 1. | The fraud cases pending with CBI/Police/Court were finally disposed off | |
| 2. | The examination of staff accountability has been completed | |
| 3. | The amount involved in the fraud has been recovered or written off | |
| 4. | The insurer has reviewed the systems and procedures; identified the causative factors; has plugged the lacunae; and the portion taken note of by appropriate authority of the insurer (Board, Committee thereof) | |
| 5. | Insurer is pursuing vigorously with CBI for final disposal of pending fraud cases, staff side action completed.<br><br>Insurer is vigorously following up with the police authorities and/or court for final disposal of fraud cases | |
| 6. | Fraud cases where:<br><br>The Investigation is on or challan/ charge sheet not filed in the Court for more than three years from the date of filing of First Information Report (FIR) by the CBI/Police; or<br><br>Trial in the courts, after filing of charge sheet / challan by CBI / Police has not started, or is in progress. | |

CERTIFICATION

Certified that the details given above are correct and complete to the best of my knowledge and belief and nothing has been concealed or suppressed.

Date: Signed/-
Place: Name of the Chief Executive Officer of the Insurer

**# Closure of Fraud Cases:**

For reporting purposes, only in the following instances of fraud cases can be considered as closed:

1. The fraud cases pending with CBI/Police/Court are finally disposed of.
2. The examination of staff accountability has been completed
3. The amount of fraud has been recovered or written off.
4. The insurer has reviewed the systems and procedures, identified the causative factors and plugged the lacunae and the fact of which has been taken note of by the appropriate authority of the insurer (Board / Audit Committee of the Board)
5. Insurers are allowed, for limited statistical / reporting purposes, to close those fraud cases, where:

    a. The Investigation is on or challan/ charge sheet not filed in the Court for more than three years from the date of filing of First Information Report (FIR) by the CBI/Police, or
    b. The trial in the courts, after filing of charge sheet / challan by CBI / Police, has not started, or is in progress.

Insurers should also pursue vigorously with CBI for final disposal of pending fraud cases especially where the insurers have completed the staff side action. Similarly, insurers may vigorously follow up with the police authorities and/or court for final disposal of fraud cases and / or court for final disposal of fraud cases.