**ICICI LOMBARD GENERAL INSURANCE COMPANY LIMITED**

# Anti-Fraud Policy

ICICI LOMBARD GENERAL INSURANCE COMPANY LIMITED (the Company) has adopted a 'ZERO TOLERANCE POLICY' towards the commission or concealment of any kind of fraudulent or illegal acts. This Anti-fraud policy (the Policy) covers all employees and officers of the Company. Additionally, this policy covers all vendors, customers, agents and business partners to the extent that any resource of the Company is involved or impacted.

The Policy recognizes the principle of proportionality and reflects the nature, scale and complexity of the business and risks which it is exposed to. Due consideration has also been given to organizational structure, insurance products being offered; technology used, market conditions and evolving patterns of fraud.

## 1. Objective:

The Insurance Regulator, Insurance Regulatory and Development Authority of India (IRDAI) issued a circular with respect to Insurance Fraud Monitoring Framework on January 21, 2013, applicable to all the Insurance and Reinsurance Companies. The circular requires all Insurers to put in place an "Anti-Fraud Policy" duly approved by its Board and also have in place a detailed set of procedural guidelines that enlist the steps and approach adopted by the company to successfully mitigate fraud.

## 2. Fraud Definition and Classification

As defined in point B of the guidelines issued by IRDAI and requirements as per Companies Act 2013, "Fraud" in relation to affairs of a company, includes any act, omission, concealment of any fact or abuse of position committed by a person or any other entity or in connivance in any manner, with intent to deceive, gain undue advantage, or 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. This may, for example, be achieved by means of:

2.1 Misappropriating assets.
2.2 Deliberately misrepresenting, concealing, suppressing or not disclosing one or more material facts relevant to the financial decision, transaction or perception of the insurer's status.
2.3 Abusing responsibility, a position of trust or a fiduciary relationship.

Additionally, such Frauds can be categorized based on the relationship of the Company with the individual(s) involved in the fraud:

**a. Intermediary Fraud**

Fraud perpetuated by an insurance agent/ corporate agent/ intermediary/ Third Party Administrations (TPAs) against the insurer and/or policyholders.

**b. Internal Fraud**

Fraud/ misappropriation against the insurer by its Director, Manager and/ or any other officer or staff member (by whatever name called).

**c. 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.

An illustrative list of Insurance frauds is given in **Appendix-1**. These instances include frauds perpetuated internally, by insurance agent/ Corporate Agent/ intermediary/ TPA's; and instances of claims/ policyholders frauds.

**d. Amount Involved in Fraud**

The amount involved shall be arrived by the nature of fraud;

- Amount in policy related forgery or tampering shall be premium
- In case of claims fraud, which was identified and the claim was repudiated or the policy was voided by the Company, the fraud amount involved shall be the claim reserve insured but the actual loss shall be "Nil"
- If the fraud has been identified post payment of claims then the total amount paid shall be considered as loss.
- For instances of proven cash/ cheque misappropriation, the amount misappropriated shall be equal to the actual loss
- In case of expense fraud, the actual amount paid shall be the amount of loss
- In case of commission fraud, the actual amount paid shall be the amount of loss

- In case of commission received fraud, the actual amount received is the amount involved in fraud

- In case of expense fraud/ commission fraud identified before payment/ receipt the amount involved should be fraud amount, but the actual loss should be 'NIL'.

## 3. Fraud Monitoring

To overcome the risk of fraud, it is imperative to identify areas of business and departments that are potentially prone to insurance frauds. It is also imperative to lay down procedures to identify, detect, investigate and report insurance frauds including online frauds relating to policy issuance and claims. Accordingly, anti-fraud procedures are formulated by the Company for identification, detection, investigation, prosecution, prevention, mitigation measures and reporting of insurance frauds.

## 4. Fraud Monitoring Function

The Fraud Monitoring Function (FMF) shall either be an independent function or be merged with existing functions such as Risk, Audit, etc. The function shall ensure effective implementation of the Policy. The Head of this function shall be at sufficiently senior management level and be able to operate independently.

The FMF shall ensure effective implementation of the Policy and shall also be responsible for the following:

4.1 Laying down procedures for internal reporting from/and to various departments.

4.2 Creating awareness among their employees/intermediaries/policyholders to counter insurance frauds.

4.3 Furnishing various reports on frauds to the Authority as stipulated in this regard and

4.4 Furnish periodic reports to the Board of Directors.

## 5. Creation of Fraud awareness in staff and customers

Awareness on how to prevent and detect frauds is the basis of fraud management. The Company adopts various measures to create awareness among staff and customers. Procedural guidelines shall be put in place creating awareness.

## 6. Co-ordination with Law Enforcement Agencies

To enable timely and expeditious reporting of fraud for the purpose of investigation and prosecution, a process for coordination with the law enforcement agencies shall be formulated by the Company.

## 7. Exchange Information

The Company shall co-operate with any industry action for exchange of information on fraud events and as required by industry forums and shall furnish necessary information relating to fraud events identified or suspected, as the case may be. Further, the Company shall make best use of the information so received to minimize or eliminate common elements of fraud risk such as common events, common entities, common areas, common activities, etc. Further, proper records of all supporting documentary evidences and reports shall be maintained as per the Record Maintenance Policy of the company.

## 8. Due Diligence

Process shall be formulated for carrying out due diligence on personnel (management and staff), insurance agent, corporate agent, intermediary and TPAs before appointing them or entering into an agreement with them.

## 9. Regular Communication Channels

The FMF shall generate fraud mitigation communication within the organization at periodic intervals and/or on an ad-hoc basis, as may be required. The FMF shall also formalize the information flow amongst the various operating departments as regards insurance frauds and or with existing or potential clients.

## 10. Reporting and Review Mechanism

The Company shall quarterly report to the Audit/Risk Committee of the Board of Directors on the events of fraud identified, established and eliminated.

The Company shall also submit to the Authority, an annual report of the statistics on various fraudulent cases which comes to light and action taken thereon in appropriate forms prescribed by the Authority. The annual report must be submitted within 30 days of close of the financial year.

Further the Board of Directors of the Company shall review the anti-fraud policy on at least an annual basis and at such intervals as may be considered necessary.

## Appendix 1

Illustrative list of insurance frauds
(Refer to clause 2 of the Policy)
(Refer to Appendix -1 of IRDAI guidelines ref: IRDA/SDD/MISC/CIR/009/01/2013)

Broadly, the potential areas of fraud include those committed by the officials of the Company, its agents, corporate agents, intermediaries, TPAs and the policyholders including their nominees. Some of the examples of fraudulent acts/omissions include, but are not limited to the following:

**1. Internal Fraud**

1.1. Misappropriating funds.
1.2. Fraudulent financial reporting.
1.3. Stealing cheques.
1.4. Overriding decline decisions so as to open accounts for family and friends
1.5. Inflating expenses claims/over billing.
1.6. Paying false (or inflated) invoices, either self-prepared or obtained through collusion with suppliers.
1.7. Permitting special prices or privileges to customers, or granting business to favoured suppliers, for kickbacks/favours.
1.8. Forging signatures.
1.9. Removing money form customer's account.
1.10. Falsifying documents.
1.11. Selling assets of the Company at below their true value in return for payment.

**2. Policyholder Fraud and Claims Fraud**

2.1. Exaggerating damages/loss.
2.2. Staging the occurrence of incidents.
2.3. Reporting and claiming of fictitious damage/loss.
2.4. Medical claims fraud.
2.5. Fraudulent Death Claims.

## 3. Intermediary Fraud

3.1. Premium diversion- intermediary takes the premium from the purchaser and does not pass it to the insurer.
3.2. Inflates the premium, passing on the correct amount to the insurer and keeping the difference.
3.3. Non-disclosure or misrepresentation of the risk to reduce premiums.
3.4. 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.